YOUR GROUP INSURANCE PLAN BENEFITS

SULLIVAN CURTIS MONROE

CLASS 0001

AD&D, VOLUNTARY AD&D, OPTIONAL LIFE, DENTAL, LTD, LIFE, VISION

The enclosed certificate is intended to explain the benefits provided by the Plan. It does not constitute the Policy Contract. Your rights and benefits are determined in accordance with the provisions of the Policy, and your insurance is effective only if you are eligible for insurance and remain insured in accordance with its terms.

This Booklet Includes All Benefits For Which You Are Eligible.

You are covered for any benefits provided to you by the policyholder at no cost.

But if you are required to pay all or part of the cost of insurance you will only be covered for those benefits you elected in a manner and mode acceptable to Guardian such as an enrollment form and for which premium has been received by Guardian.

"Please Read This Document Carefully".

CERTIFICATE OF COVERAGE

The Guardian
7 Hanover Square
New York, New York 10004

We, The Guardian, certify that the employee named below is entitled to the insurance benefits provided by The Guardian described in this certificate, provided the eligibility and effective date requirements of the plan are satisfied.

Group Policy No.	Certificate No.	Effective Date
Issued To		

This CERTIFICATE OF COVERAGE replaces any CERTIFICATE OF COVERAGE previously issued under the above Plan or under any other Plan providing similar or identical benefits issued to the Planholder by The Guardian.

The Guardian Life Insurance Company of America

Stuart J Shaw
Vice President, Risk Mgt. & Chief Actuary

CGP-3-R-STK-90-3 B110.0023

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SECTION I: Non-Managed DentalGuard Insurance

This part of your booklet does not apply to your plan of Managed DentalGuard dental care expense insurance.

Your Managed DentalGuard dental care expense insurance plan appears later in this booklet.

B850.0181

COMPLAINT NOTICE

This notice is to advise you that should any complaints arise regarding this insurance you may contact the Guardian at the following address or phone number:

The Guardian Sales Office
801 Parkview Drive North, Suite 100
El Segundo, CA 90245
Telephone: (310) 765-2200
(800) 225-3399
Fax: (310) 765-2040

If you feel your complaints have not been resolved after contacting the Guardian you may contact the California Department of Insurance at the following address or phone number:

Department of Insurance
300 South Spring St.
Los Angeles, CA 90013

Consumer Hotline: 1-800-927-4357

CGP-3-CADISC-91 B120.0011

All Options

Dental Services Not Covered By This Plan

IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call member services at 1-888-618-2016 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

CGP-3-CADISC B120.0074

GENERAL PROVISIONS

As used in this booklet:

"Accident and health" means any dental, dismemberment, hospital, long term disability, major medical, out-of-network point-of-service, prescription drug, surgical, vision care or weekly loss-of-time insurance provided by this *plan.*

"Covered person" means an *employee* or a dependent insured by this *plan.*

"Employer" means the *employer* who purchased this *plan.*

"Our," "The Guardian," "us" and "we" mean The Guardian Life Insurance Company of America.

"Plan" means the Guardian *plan* of group insurance purchased by your *employer.*

"You" and "your" mean an *employee* insured by this *plan.*

CGP-3-R-GENPRO-90 B160.0002

Limitation of Authority

No person, except by a writing signed by the President, a Vice President or a Secretary of The Guardian, has the authority to act for us to: (a) determine whether any contract, plan or certificate of insurance is to be issued; (b) waive or alter any provisions of any insurance contract or plan, or any requirements of The Guardian; (c) bind us by any statement or promise relating to any insurance contract issued or to be issued; or (d) accept any information or representation which is not in a signed application.

CGP-3-R-LOA-90 B160.0004

All Options

Incontestability

This *plan* is incontestable after two years from its date of issue, except for non-payment of premiums.

No statement in any application, except a fraudulent statement, made by a person insured under this *plan* shall be used in contesting the validity of his insurance or in denying a claim for a loss incurred, or for a disability which starts, after such insurance has been in force for two years during his lifetime.

If this *plan* replaces a plan your *employer* had with another insurer, we may rescind the *employer's plan* based on misrepresentations made by the *employer* in a signed application for up to two years from the effective date of this *plan.*

CGP-3-R-INCY-96 B160.0061

All Options

Examination and Autopsy

We have the right to have a *doctor* of our choice examine the person for whom a claim is being made under this *plan* as often as we feel necessary. And we have the right to have an autopsy performed in the case of death, where allowed by law. We'll pay for all such examinations and autopsies.

CGP-3-R-EA-90 B160.0006

All Options

Accident and Health Claims Provisions

Your right to make a claim for any *accident and health* benefits provided by this *plan,* is governed as follows:

Notice You must send us written notice of an *injury* or *sickness* for which a claim is being made within 20 days of the date the *injury* occurs or the *sickness* starts. This notice should include your name and *plan* number. If the claim is being made for one of your *covered dependents,* his or her name should also be noted.

Proof of Loss We'll furnish you with forms for filing proof of loss within 15 days of receipt of notice. But if we don't furnish the forms on time, we'll accept a written description and adequate documentation of the *injury* or *sickness* that is the basis of the claim as proof of loss. You must detail the nature and extent of the loss for which the claim is being made. You must send us written proof within 90 days of the loss.

If this plan provides weekly loss-of-time insurance, you must send us written proof of loss within 90 days of the end of each period for which we're liable. If this plan provides long term disability income insurance, you must send us written proof of loss within 90 days of the date we request it. For any other loss, you must send us written proof within 90 days of the loss.

Late Notice of Proof We won't void or reduce your claim if you can't send us notice and proof of loss within the required time. But you must send us notice and proof as soon as reasonably possible.

Payment of Benefits We'll pay benefits for loss of income once every 30 days for as long as we're liable, provided you submit periodic written proof of loss as stated above. We'll pay all other *accident and health* benefits to which you're entitled as soon as we receive written proof of loss.

We pay all *accident and health* benefits to you, if you're living. If you're not living, we have the right to pay all *accident and health* benefits, except dismemberment benefits, to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; (e) your brothers and sisters; and (f) any unpaid provider of health care services. See "Your Accidental Death and Dismemberment Benefits" for how dismemberment benefits are paid.

When you file proof of loss, you may direct us, in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. We may honor such direction at our option. But we can't tell you that a particular provider must provide such care. And you may not assign your right to take legal action under this *plan* to such provider.

Limitations of Actions You can't bring a legal action against this *plan* until 60 days from the date you file proof of loss. And you can't bring legal action against this *plan* after three years from the date you file proof of loss.

Workers' Compensation The *accident and health* benefits provided by this *plan* are not in place of, and do not affect requirements for coverage by Workers' Compensation.

Coordination Between Continuation Sections

A covered person may be eligible to continue his group health benefits under this plan's "Federal Continuation Rights" section and under other continuation sections of this plan at the same time. If he chooses to continue his group health benefits under more than one section, the continuations: (a) start at the same time; (b) run concurrently; and (c) end independently, on their own terms.

A covered person covered under more than one of this plan's continuation sections: (a) will not be entitled to duplicate benefits; and (b) will not be subject to the premium requirements of more than one section at the same time.

CGP-3-R-COC-87 B240.0044

An Important Notice About Continuation Rights

The following "Federal Continuation Rights" section may not apply to the employer's plan. The employee must contact his employer to find out if: (a) the employer is subject to the "Federal Continuation Rights" section, and therefore; (b) the section applies to the employee.

CGP-3-R-NCC-87 B240.0064

YOUR CONTINUATION RIGHTS

Federal Continuation Rights

Important Notice

This notice contains important information about the right to continue group dental coverage. In addition to the continuation rights described below, other health coverage alternatives may be available through states' Health Insurance Marketplaces. Please read the information contained in this notice very carefully.

This section applies only to any dental, out-of-network point-of-service medical, major medical, prescription drug or vision coverages which are part of this plan. In this section, these coverages are referred to as "group health benefits."

This section does not apply to any coverages which apply to loss of life, or to loss of income due to disability. These coverages can not be continued under this section.

Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this plan as: (a) an active, covered employee; (b) the spouse of an active covered employee; or (c) the dependent child of an active, covered employee. A child born to, or adopted by, the covered employee during a continuation period is also a qualified continuee. Any other person who becomes covered under this plan during a continuation provided by this section is not a qualified continuee.

Conversion

Continuing the group health benefits does not stop a qualified continuee from converting some of these benefits when continuation ends. But, conversion will be based on any applicable conversion privilege provisions of this plan in force at the time the continuation ends.

If Your Group Health Benefits End

If your group health benefits end due to your termination of employment or reduction of work hours, you may elect to continue such benefits for up to 18 months, if you were not terminated due to gross misconduct.

The continuation: (a) may cover you or any other qualified continuee; and (b) is subject to "When Continuation Ends".

Extra Continuation for Disabled Qualified Continuees

If a qualified continuee is determined to be disabled under Title II or Title XVI of the Social Security Act on or during the first 60 days after the date his or her group health benefits would otherwise end due to your termination of employment or reduction of work hours, and such disability lasts at least until the end of the 18 month period of continuation coverage, he or she or any member of that person's family who is a qualified continuee may elect to extend his or her 18 month continuation period explained above for up to an extra 11 months.

To elect the extra 11 months of continuation, a qualified continuee must give your employer written proof of Social Security's determination of the disabled qualified continuee's disability as described in "The Qualified Continuee's Responsibilities". If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify your employer within 30 days of such determination, and continuation will end, as explained in "When Continuation Ends."

This extra 11 month continuation is subject to "When Continuation Ends".

An additional 50% of the total premium charge also may be required from all qualified continuees who are members of the disabled qualified continuee's family by your employer during this extra 11 month continuation period, provided the disabled qualified continuee has extended coverage.

CGP-3-R-COBRA-96-1 B235.0631

All Options

If You Die While Insured

If you die while insured, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to "When Continuation Ends".

CGP-3-R-COBRA-96-2 B235.0075

All Options

If Your Marriage Ends

If your marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to "When Continuation Ends".

If a Dependent Child Loses Eligibility

If a dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this plan, other than your coverage ending, he or she may elect to continue such benefits. However, such dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to "When Continuation Ends".

Concurrent Continuations

If a dependent elects to continue his or her group health benefits due to your termination of employment or reduction of work hours, the dependent may elect to extend his or her 18 month or 29 month continuation period to up to 36 months, if during the 18 month or 29 month continuation period, the dependent becomes eligible for 36 months of continuation due to any of the reasons stated above.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

Special Medicare Rule

If you become entitled to Medicare before a termination of employment or reduction of work hours, a special rule applies for a dependent. The continuation period for a dependent, after your later termination of employment or reduction of work hours, will be the longer of: (a) 18 months (29 months if there is a disability extension) from your termination of employment or reduction of work hours; or (b) 36 months from the date of your earlier entitlement to Medicare. If Medicare entitlement occurs more than 18 months before termination of employment or reduction of work hours, this special Medicare rule does not apply.

The Qualified Continuee's Responsibilities

A person eligible for continuation under this section must notify your employer, in writing, of: (a) your legal divorce or legal separation from your spouse; (b) the loss of dependent eligibility, as defined in this plan, of an insured dependent child; (c) a second event that would qualify a person for continuation coverage after a qualified continuee has become entitled to continuation with a maximum of 18 or 29 months; (d) a determination by the Social Security Administration that a qualified continuee entitled to receive continuation with a maximum of 18 months has become disabled during the first 60 days of such continuation; and (e) a determination by the Social Security Administration that a qualified continuee is no longer disabled.

Notice of an event that would qualify a person for continuation under this section must be given to your employer by a qualified continuee within 60 days of the latest of: (a) the date on which an event that would qualify a person for continuation under this section occurs; (b) the date on which the qualified continuee loses (or would lose) coverage under this plan as a result of the event; or (c) the date the qualified continuee is informed of the responsibility to provide notice to your employer and this plan's procedures for providing such notice.

Notice of a disability determinaton must be given to your employer by a qualified continuee within 60 days of the latest of: (a) the date of the Social Security Administration determination; (b) the date of the event that would qualify a person for continuation; (c) the date the qualified continuee loses or would lose coverage; or (d) the date the qualified continuee is informed of the responsibility to provide notice to your employer and this plan's procedures for providing such notice. But such notice must be given before the end of the first 18 months of continuation coverage.

All Options

Your Employer's Responsibilities

A qualified continuee must be notified, in writing, of: (a) his or her right to continue this plan's group health benefits; (b) the premium he or she must pay to continue such benefits; and (c) the times and manner in which such payments must be made.

Your employer must give notice of the following qualifying events to the plan administrator within 30 days of the event: (a) your death; (b) termination of employment (other than for gross misconduct) or reduction in hours of employment; (c) Medicare entitlement; or (d) if you are a retired employee, a bankruptcy proceeding under Title 11 of the United States Code with respect to the employer. Upon receipt of notice of a qualifying event from your employer or from a qualified continuee, the plan administrator must notify a qualified continuee of the right to continue this plan's group health benefits no later than 14 days after receipt of notice.

If your employer is also the plan administrator, in the case of a qualifying event for which an employer must give notice to a plan administrator, your employer must provide notice to a qualified continuee of the right to continue this plan's group health benefits within 44 days of the qualifying event.

If your employer determines that an individual is not eligible for continued group health benefits under this plan, they must notify the individual with an explanation of why such coverage is not available. This notice must be provided within the time frame described above.

If a qualified continuee's continued group health benefits under this plan are cancelled prior to the maximum continuation period, your employer must notify the qualified continuee as soon as practical following determination that the continued group health benefits shall terminate.

Your Employer's Liability

Your employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of, us, if: (a) he or she fails to remit a qualified continuee's timely premium payment to us on time, thereby causing the qualified continuee's continued group health benefits to end; or (b) he or she fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation

To continue his or her group health benefits, the qualified continuee must give your employer written notice that he or she elects to continue. This must be done by the later of: (a) 60 days from the date a qualified continuee receives notice of his or her continuation rights from your employer as described above; or (b) the date coverage would otherwise end. And the qualified continuee must pay his or her first premium in a timely manner.

The subsequent premiums must be paid to your employer, by the qualified continuee, in advance, at the times and in the manner specified by your employer. No further notice of when premiums are due will be given.

The premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed insured under the group plan on a regular basis. It includes any amount that would have been paid by your employer. Except as explained in "Extra Continuation for Disabled Qualified Continuees", an additional charge of two percent of the total premium charge may also be required by your employer.

If the qualified continuee fails to give your employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums

A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified due date. If timely payment is made to the plan in an amount that is not significantly less than the amount the plan requires to be paid for the period of coverage, then the amount paid is deemed to satisfy the requirement for the premium that must be paid; unless your employer notifies the qualified continuee of the amount of the deficiency and grants an additional 30 days for payment of the deficiency to be made. Payment is calculated to be made on the date on which it is sent to your employer.

When Continuation Ends

A qualified continuee's continued group health benefits end on the first of the following:

(1) with respect to continuation upon your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;

(2) with respect to a qualified continuee who has an additional 11 months of continuation due to disability, the earlier of: (a) the end of the 29 month period which starts on the date the group health benefits would otherwise end; or (b) the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that the disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;

(3) with respect to continuation upon your death, your legal divorce, or legal separation, or the end of an insured dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

(4) the date the employer ceases to provide any group health plan to any employee;

(5) the end of the period for which the last premium payment is made;

(6) the date, after the date of election, he or she becomes covered under any other group health plan which does not contain any pre-existing condition exclusion or limitation affecting him or her; or

(7) the date, after the date of election, he or she becomes entitled to Medicare.

Uniformed Services Continuation Rights

If you enter or return from military service, you may have special rights under this *plan* as a result of the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

If your group health benefits under this *plan* would otherwise end because you enter into active military service, this *plan* will allow you, or your dependents, to continue such coverage in accord with the provisions of USERRA. As used here, "group health benefits" means any dental, out-of-network point-of service medical, major medical, prescription drug or vision coverages which are part of this *plan.*

Coverage under this plan may be continued while you are in the military for up to a maximum period of 24 months beginning on the date of absence from work. Continued coverage will end if you fail to return to work in a timely manner after military service ends as provided under USERRA. You should contact your employer for details about this continuation provision including required premium payments.

CGP-3-R-COBRA-96-4 B235.0195

All Options

ELIGIBILITY FOR LIFE AND DISMEMBERMENT COVERAGES

B264.0003

All Options

Employee Coverage

Eligible Employees

To be eligible for employee coverage, you must be an active *full-time employee.* And you must belong to a class of *employees* covered by this *plan.*

Other Conditions

You must:

(a) be legally working in the United States, or working outside the United States for a United States based employer in a country or region approved by us.

(b) be regularly working at least the number of hours in the normal work week set by your *employer* (but not less than 30 hours per week), at:

(i) your *employer's* place of business;

(ii) some place where your *employer's* business requires you to travel; or

(iii) any other place you and your *employer* have agreed upon for performance of occupational duties.

If you must pay all or part of the cost of employee coverage, we won't insure you until you enroll and agree to make the required payments. If you do this: (a) more than 31 days after you first become eligible; or (b) after you previously had coverage which ended because you failed to make a required payment, we also ask for *proof* that you're insurable. And you won't be covered until we approve that *proof* in writing.

Part or all of your insurance amounts may be subject to *proof* that you're insurable. The Life Schedule explains if and when we require *proof.* You won't be covered for any amount that requires such *proof* until you give the *proof* to us and we approve it in writing.

If your active *full-time* service ends before you meet any *proof of insurability* requirements that apply to you, you'll still have to meet those requirements if you're later re-employed.

CGP-3-EC-90-1.0 B264.2490

All Options

When Your Coverage Starts

Employee benefits that don't require *proof* that you are insurable are scheduled to start on the effective date shown on the sticker attached to the inside front cover of this booklet.

Employee benefits that require such *proof* won't start until you send us the *proof* and we approve it in writing. Once we have approved it, the benefits are scheduled to start on the effective date shown in the endorsement section of your application. A copy of the approved application is furnished to you.

But you must be fully capable of performing the major duties of your regular occupation for your *employer* on a full-time basis at 12:01AM Standard Time for your place of residence on the scheduled effective date or dates. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are not fully capable of performing the major duties of your regular occupation on any date part of your insurance is scheduled to start we will postpone that part of your coverage. We will postpone that part of your coverage until the date you are so capable and are working your regular number of hours for one full day, with the expectation that you could do so for one full week.

Sometimes, the effective date shown on the sticker or in the endorsement is not a regularly scheduled work day. If the scheduled effective date falls: on a holiday; on a vacation day; on a non-scheduled work day; or during an approved leave of absence, not due to sickness or injury, of 90 days or less; and if you were performing the major duties of your regular occupation and working your regular number of hours on your last regularly scheduled work day, your coverage will start on the scheduled effective date. However, any coverage or part of coverage for which you must elect and pay all or part of the cost, will not start if you are on an approved leave and such coverage or part of coverage was not previously in force for you under a prior plan which this *plan* replaced.

CGP-3-EC-90-2.0 B264.1255

All Options

Delayed Effective Date For Employee Optional Life Coverage

With respect to this *plan's* employee optional group term life insurance, if an *employee* is not actively at work on a *full- time* basis on the date his or her coverage is scheduled to start, due to *sickness* or *injury,* we'll postpone coverage for an otherwise covered loss due to that condition. We'll postpone such coverage until he or she completes 10 consecutive days of active *full-time* service without missing a work day due to the same condition.

Coverage for an otherwise covered loss due to all other conditions will start on the date the *employee* returns to active *full-time* service.

CGP-3-DEF-97 B270.0384

All Options

When Your Coverage Ends

Your coverage ends on the date your active *full-time* service ends for any reason. Such reasons include disability, death, retirement, layoff, leave of absence and the end of employment.

It also ends on the date you stop being a member of a class of employees eligible for insurance under this *plan,* or when this *plan* ends for all employees. And it ends when this *plan* is changed so that benefits for the class of employees to which you belong ends.

It ends on the date you are no longer working in the United States unless you are on a temporary assignment: (1) not exceeding one year in a country or region that is not under a travel warning issued by the US Department of State; or (2) for which we have agreed, in writing, to provide coverage.

If you are required to pay all or part of the cost of this coverage and you fail to do so, your coverage ends. It ends on the last day of the period for which you made the required payments, unless coverage ends earlier for other reasons.

Read this booklet carefully if your coverage ends. You may have the right to continue certain group benefits for a limited time. And you may have the right to replace certain group benefits with converted policies.

CGP-3-EC-90-3.0 B264.1385

An Employee's Right To Continue Group Life and AD&D Insurance During a Family Leave Of Absence

All Options

Important Notice This section may not apply to an *employer's* plan. You must contact your *employer* to find out if your *employer* must allow for a leave of absence under federal law. In that case the section applies.

Continuation of Coverages Life and accidental death and dismemberment coverages may be continued, under a uniform, non-discriminatory policy applicable to all employees. You must contact your *employer* to find out if you may continue these coverages.

If Your Group Insurance Would End Group life and accidental death and dismemberment insurance may normally end for an *employee* because he or she ceases work due to an approved leave of absence. But, the *employee* may continue his or her group coverage if the leave of absence has been granted: (a) to allow the *employee* to care for a seriously injured or ill spouse, child or parent; (b) after the birth or adoption of a child; (c) due to the *employee's* own serious health condition; or (d) because of any serious injury or illness arising out of the fact that a spouse, child, parent, or next of kin, who is a covered servicemember, of the *employee* is on active duty(or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation. The *employee* will be required to pay the same share of the premium as he or she paid before the leave of absence.

When Continuation Ends Coverage may continue until the earliest of the following:

- The date you return to active work.
- In the case of a leave granted to you to care for a covered servicemember: The end of a total leave period of 26 weeks in one 12 month period. This 26 week total leave period applies to all leaves granted to you under this section for all reasons. If you take an additional leave of absence in a subsequent 12 month period, continued coverage will cease at the end of a total leave period of 12 weeks.

- In any other case: The end of a total leave period of 12 weeks in any 12 month period.
- The date on which your *Employer's Plan* is terminated or you are no longer eligible for coverage under this *Plan.*
- The end of the period for which the premium has been paid.

Definitions As used in this section, the terms listed below have the meanings shown below:

- **Active Duty:** This term means duty under a call or order to active duty in the Armed Forces of the United States.
- **Contingency Operation:** This term means a military operation that: (a) is designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force; or (b) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law during a war or during a national emergency declared by the President or Congress.
- **Covered Servicemember:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness: (a), is undergoing medical treatment, recuperation, or therapy; (b) is otherwise in outpatient status; or (c) is otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means the nearest blood relative of the *employee.*
- **Outpatient Status:** This term means, with respect to a covered servicemember, that he or she is assigned to: (a) a military medical treatment facility as an outpatient; or (b) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.
- **Serious Injury Or Illness:** This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her office, grade, rank, or rating.

CGP-3-EC-90-3.0 B264.2455

Dependent Life Coverage

All Options

CGP-3-DEP-90-1.0 B264.0056

All Options

Eligible Dependents For Optional Dependent Life Benefits

Your *eligible dependents* are: your legal spouse who is under age 70, and your unmarried dependent children, until they reach age 26 and your unmarried dependent children, from age 26 until they reach age 26, who are enrolled as full-time students at accredited schools.

CGP-3-DEP-90-3.0 B264.2669

All Options

Adopted Children And Step-Children

Your "unmarried dependent children" include your legally adopted children and, if they depend on you for most of their support and maintenance, your step-children. We treat a child as legally adopted if the child is in your legal custody under an interim court order of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

Dependents Not Eligible

We exclude any dependent who is on active duty in any armed force.

CGP-3-DEP-90-3.1 B264.2594

All Options

Handicapped Children

You may have an unmarried child with a mental or physical handicap, or developmental disability, who can't support himself. Subject to all of the terms of this section and the *plan,* such a child may stay eligible for dependent health benefits past this *plan's* age limit.

The child will stay eligible as long as he stays unmarried and unable to support himself, if: (a) his conditions started before he reached this *plan's* age limit; (b) he became insured by this *plan* before he reached the age limit, and stayed continuously insured until he reached such limit; (c) he depends on you for most of his support and maintenance.

But, for the child to stay eligible, you must send us written *proof* that the child is handicapped and depends on you for most of his support and maintenance. You have 31 days from the date the child reaches the age limit to do this. We can ask for periodic *proof* that the child's condition continues. But, after two years, we can't ask for this *proof* more than once a year.

The child's coverage ends when yours does.

CGP-3-DEP-90-4.0 B264.0541

All Options

Proof Of Insurability

We require *proof* that a dependent is insurable, if you: (a) enroll a dependent and agree to make the required payments after the end of the *enrollment period;* (b) in the case of a newly acquired dependent, other than the first newborn child, have other eligible dependents who you have not elected to enroll; or (c) in the case of a *newly acquired dependent,* have other *eligible dependents* whose coverage previously ended because you failed to make the required contributions, or otherwise chose to end such coverage.

A dependent is not insured by any part of this *plan* that requires such *proof* until you give us this *proof,* and we approve it in writing.

If the dependent coverage ends for any reason, including failure to make the required payments, your dependents won't be covered by this *plan* again until you give us new *proof* that they're insurable and we approve that *proof* in writing.

CGP-3-DEP-90-5.0 B200.0288

All Options

When Dependent Coverage Starts

In order for your dependent coverage to begin you must already be insured for employee coverage, or enroll for employee and dependent coverage at the same time. Subject to the "Exception" stated below and to all of the terms of this *plan,* the date your dependent coverage starts depends on when you elect to enroll your *initial dependents* and agree to make any required payments.

If you do this on or before your *eligibility date,* the dependent's coverage is scheduled to start on the later of the first of the month which coincides with or next follows your *eligibility date* and the date you become insured for employee coverage.

If you do this within the *enrollment period,* the coverage is scheduled to start on the later of the first of the month which coincides with or next follows the date you sign the enrollment form; and the date you become insured for employee coverage.

If you do this after the *enrollment period* ends, your dependent coverage is subject to *proof of insurability* and won't start until we approve that *proof* in writing.

Once you have dependent coverage for your *initial dependents,* you must notify us when you acquire any new dependents and agree to make any additional payments required for their coverage.

A *newly acquired dependent* will be covered for those dependent benefits not subject to *proof of insurability* from the later of the date you notify us and agree to make any additional payments, and the date the *newly acquired dependent* is first eligible.

If *proof of insurability* is required for dependent benefits as explained above, those benefits are scheduled to start, subject to the "Exception" stated below, on the effective date shown in the "Endorsement" section of your application, provided that you send us the *proof* we require and we approve that *proof* in writing. A copy of the approved application is furnished to you.

CGP-3-DEP-90-6.0 B200.0314

All Options

Exception If a dependent, other than a newborn child, is confined to a *hospital* or other health care facility; or is home-confined; or is unable to carry out the normal activities of someone of like age and sex on the date his dependent benefits would otherwise start, we will postpone the effective date of such benefits until the day after his discharge from such facility; until home confinement ends; or until he resumes the normal activities of someone of like age and sex.

CGP-3-DEP-90-7.0 B200.0692

All Options

When Dependent Coverage Ends Dependent coverage ends for all of your dependents when your employee coverage ends. Dependent coverage also ends for all of your dependents when you stop being a member of a class of *employees* eligible for such coverage. And it ends when this *plan* ends, or when dependent coverage is dropped from this *plan* for all *employees* or for an *employee's* class.

If you are required to pay part of the cost of dependent coverage, and you fail to do so, your dependent coverage ends. It ends on the last day of the period for which you made the required payments, unless coverage ends earlier for other reasons.

An individual dependent's coverage ends when he stops being an *eligible dependent.* This happens to a child at 12:01 a.m. on the date the child attains this *plan's* age limit, when he marries, or when a step-child is no longer dependent on the employee for support and maintenance. It happens to a spouse when a marriage ends in legal divorce or annulment, and with respect to optional life coverage, it happens at 12:01 a.m. on the date the spouse reaches age 70.

Read this plan carefully if dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time. And they may have the right to replace certain group benefits with converted policies.

CGP-3-DEP-90-9.0 B200.0792

CERTIFICATE AMENDMENT

Effective March 1, 2011, this rider amends the dependent coverage provisions as follows:

Your domestic partner will be eligible for coverage under this plan subject to all of the terms of this plan and the limitations below. "Domestic partner" means an adult who has chosen to share his or her life with you in an intimate and committed relationship of mutual caring.

To qualify for such coverage, you and your domestic partner must be registered domestic partners.

As used here:

"Registered domestic partners" means an employee and his or her domestic partner who: (a) have filed a Declaration of Domestic Partnership with the California Secretary of State; (b) were registered as a domestic partner in the registry for those partnerships; and (c) were issued a copy of the registered form and a Certificate of Registered Domestic Partnership.

Your registered domestic partner will be eligible for dependent optional life coverage under this plan.

A registered domestic partner's dependent children will be eligible for coverage under this plan on the same basis as if the children were your dependent children.

Coverage for a registered domestic partner and his or her dependent children ends when the domestic partnership is dissolved as provided under California law.

This rider is a part of this plan. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this plan.

The Guardian Life Insurance Company of America

Stuart J Shaw
Vice President, Risk Mgt. & Chief Actuary

CGP-3-A-DMST-CA-05 B264.0974

All Options

GROUP TERM LIFE INSURANCE SCHEDULE

CGP-3-R-SCH-90 B265.0002

All Options

Employee Basic Term Life Insurance

CGP-3-R-SCH-90 B265.0003

All Options

Your Basic Term Life Insurance Amount An amount equal to 200% of your annual earnings, rounded to the next higher $1,000.00, if not already a multiple thereof, to a maximum of $600,000.00.

CGP-3-R-SCH-90 B265.0008

All Options

Redetermination Subject to any of the plan's proof of insurability requirements, your basic life insurance amount will be redetermined each February 1st , to an amount in accordance with the parameters enumerated above, on the basis of your then current annual earnings. If you are not actively at work on a full-time basis on that date, your insurance amount will be redetermined on the date you return to active full-time service. However, if your benefits were previously reduced because of an age or retirement reduction, your benefit will not be redetermined due to your change in earnings.

CGP-3-R-SCH-90 B265.0014

All Options

Earnings Definition

Annual earnings means your annual rate of earnings as figured from the W-2 form received from your employer for the prior calendar year. We include as earnings: (a) taxable earned income, including: (i) bonuses; (ii) commissions; and (iii) overtime pay; (b) elective employee pre-tax deferrals to a Section 125 plan or flexible spending account; and (c) contributions to a cash or deferred compensation plan, or a salary reduction plan, qualified under IRC Section 401(k), 403(b) or 457, as reported on your W-2 form.

We do not include as earnings: (1) expense accounts and other extra compensation; (2) stock options exercised; or (3) employer contributions to a cash or deferred compensation plan or salary reduction plan. If you have not worked for your employer for the entire prior calendar year, your annual earnings are based on your average rate of monthly earnings during such calendar year, multiplied by 12.

Annual earnings is calculated using the earnings components described above applicable as of the most current redetermination date on which your employer has provided earnings data to us. Proof of earnings will be required. Proof may consist of: (1) copies of your U.S. Individual Income Tax Returns; (2) a statement from a certified public accountant; or (3) any other records we agree to accept.

CGP-3-R-SCH-90 B265.1221

All Options

Reduction of Basic Life Insurance Amount Based on Age

If an employee is less than age 65 when his or her insurance under this plan starts, his or her insurance amount is reduced, on the date he or she reaches age 65, by 35% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 65 but before he or she reaches age 70.

If an employee is less than age 70 when his or her insurance under this plan starts, the employee's basic life insurance amount is reduced, when he or she reaches age 70, by 50% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 70.

CGP-3-R-SCH-90 B265.0483

All Options

Limitations For Future Entrants

However, regardless of any of the above reductions, we limit the amount of insurance for which you are eligible if your insurance under this plan starts both: (a) after this plan's effective date; and (b) after you reach age 70.

If you provide us with proof of insurability, and we approve it in writing, the amount of your insurance will be 50% of the amount which otherwise applies to your classification and/or option. But in no event will this reduced amount be less than $10,000.00.

If we do not approve the proof, your insurance amount will be $10,000.00.

CGP-3-R-SCH-90 B265.0569

All Options

Employee Basic Accidental Death and Dismemberment Insurance (AD&D)

CGP-3-R-SCH-90 B265.0029

All Options

Your Basic AD&D Insurance Amount

An amount equal to 200% of your annual earnings, rounded to the next higher $1,000.00, if not already a multiple thereof, to a maximum of $600,000.00.

CGP-3-R-SCH-90 B265.0035

All Options

Spousal Education and Retraining Benefit

Lifetime Maximum Benefit

$20,000

Maximum Number Of Benefit Payments

Full-Time Post Secondary Education 8

Part-Time Post Secondary Education 4

CGP-3-R-SCH-90 B265.0847

All Options

Dependent Child Education Benefit

Lifetime Maximum Benefit $20,000.00 per eligible dependent

Maximum Number Of Benefit Payments 8 per lifetime per eligible dependent

Maximum Benefit Period 6 years from the date the first education benefit is made; per eligible dependent.

CGP-3-R-SCH-90 B265.0848

All Options

Redetermination Subject to any of the plan's proof of insurability requirements, your basic AD&D insurance amount will be redetermined each February 1st , to an amount in accordance with the parameters enumerated above, on the basis of your then current annual earnings. If you are not actively at work on a full-time basis on that date, your insurance amount will be redetermined on the date you return to active full-time service. However, if your benefits were previously reduced because of an age or retirement reduction, your benefit will not be redetermined due to your change in earnings.

CGP-3-R-SCH-90 B265.0040

All Options

Earnings Definition Annual earnings means your annual rate of earnings as figured from the W-2 form received from your employer for the prior calendar year. We include as earnings: (a) taxable earned income, including: (i) bonuses; (ii) commissions; and (iii) overtime pay; (b) elective employee pre-tax deferrals to a Section 125 plan or flexible spending account; and (c) contributions to a cash or deferred compensation plan, or a salary reduction plan, qualified under IRC Section 401(k), 403(b) or 457, as reported on your W-2 form.

We do not include as earnings: (1) expense accounts and other extra compensation; (2) stock options exercised; or (3) employer contributions to a cash or deferred compensation plan or salary reduction plan. If you have not worked for your employer for the entire prior calendar year, your annual earnings are based on your average rate of monthly earnings during such calendar year, multiplied by 12.

Annual earnings is calculated using the earnings components described above applicable as of the most current redetermination date on which your employer has provided earnings data to us. Proof of earnings will be required. Proof may consist of: (1) copies of your U.S. Individual Income Tax Returns; (2) a statement from a certified public accountant; or (3) any other records we agree to accept.

CGP-3-R-SCH-90 B265.1221

All Options

Reduction of Basic AD&D Amount Based on Age

If an employee is less than age 65 when his or her insurance under this plan starts, his or her insurance amount is reduced, on the date he or she reaches age 65, by 35% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 65 but before he or she reaches age 70.

If an employee is less than age 70 when his or her insurance under this plan starts, the employee's insurance amount is reduced, when he or she reaches age 70, by 50% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 70.

CGP-3-R-SCH-90 B265.0494

All Options

Limitations For Future Entrants

However, regardless of any of the above reductions, we limit the amount of insurance for which you are eligible if your insurance under this plan starts both: (a) after this plan's effective date; and (b) after you reach age 70.

If you provide us with proof of insurability, and we approve it in writing, the amount of your insurance will be 50% of the amount which otherwise applies to your classification and/or option. But in no event will this reduced amount be less than $10,000.00.

If we do not approve the proof, your insurance amount will be $10,000.00.

CGP-3-R-SCH-90 B265.0571

All Options

Employee Optional Contributory Term Life Insurance

CGP-3-R-SCH-90 B265.0055

All Options

Optional Life Election

You may choose to be insured under the plan of optional term life insurance shown below. You must notify the employer of your election and pay the required premium.

CGP-3-R-SCH-90 B265.0799

All Options

Your Optional Term Life Insurance Amount

Plan A

You may elect amounts of optional term life insurance in increments of $10,000.00, but your amount may not be less than $20,000.00 and may not exceed $500,000.00.

CGP-3-R-SCH-90 B265.0063

All Options

Reduction of Optional Life Insurance Amount Based on Age

If an employee is less than age 65 when his or her insurance under this plan starts, his or her insurance amount is reduced, on the date he or she reaches age 65, by 35% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 65 but before he or she reaches age 70.

If an employee is less than age 70 when his or her insurance under this plan starts, the employee's optional life insurance amount is reduced, when he or she reaches age 70, by 50% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 70.

CGP-3-R-SCH-90 B265.0520

All Options

Proof of Insurability Requirements

Proof of insurability requirements apply to your optional term life insurance. Such requirements may apply to your full benefit amount or just part of it. When *proof of insurability* requirements apply, it means you must submit to us *proof* that you're insurable, and we must approve your *proof* in writing before your insurance, or the specified part becomes effective.

We require *proof* as follows:

CGP-3-R-SCH-90 B265.0431

All Options

We require *proof* before an *employee* switches from his or her current increment of optional term life insurance to an increment which provides a greater amount of insurance.

CGP-3-R-SCH-90 B265.0732

All Options

We require *proof* before we will insure any *employee* who enrolls for optional term life insurance after the time allowed for enrolling as specified in this *plan.*

CGP-3-R-SCH-90 B265.0435

All Options

We require *proof* before an *employee* switches from his or her current *plan* of optional term life insurance to a *plan* which provides greater benefits.

CGP-3-R-SCH-90 B265.0436

All Options

We require *proof* for amounts of optional term life insurance in excess of $100,000.00.

CGP-3-R-SCH-90 B265.0437

All Options

We require *proof* for amounts of optional term life insurance in excess of $10,000.00, if an *employee*'s scheduled optional term life effective date is after he or she reaches age 65.

CGP-3-R-SCH-90 B265.0697

All Options

We require *proof* for all amounts of optional term life insurance, if an *employee*'s scheduled optional term life effective date is after he or she reaches age 70.

CGP-3-R-SCH-90 B265.0702

All Options

Employee Voluntary Accidental Death and Dismemberment Insurance (AD&D)

CGP-3-R-SCH-90 B265.0443

All Options

Voluntary AD&D Enrollment Period

You may choose to be insured under the plan of voluntary AD&D insurance shown below. You must notify the employer of your election and pay the required premium.

CGP-3-R-SCH-90 B265.0926

All Options

Your Voluntary AD&D Insurance Amount

Plan A

You may elect amounts of voluntary AD&D insurance in increments of $10,000.00, but your amount may not be less than $20,000.00 and may not exceed $500,000.00.

CGP-3-R-SCH-90 B265.0251

All Options

Reduction of Voluntary AD&D Amount Based on Age

If an employee is less than age 65 when his or her insurance under this plan starts, his or her insurance amount is reduced, on the date he or she reaches age 65, by 35% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 65 but before he or she reaches age 70.

If an employee is less than age 70 when his or her insurance under this plan starts, the employee's optional life insurance amount is reduced, when he or she reaches age 70, by 50% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 70.

CGP-3-R-SCH-90 B265.0531

All Options

Proof of Insurability Requirements

Proof of insurability requirements apply to your voluntary AD&D insurance. Such requirements may apply to your full *benefit amount* or just part of it. When *proof of insurability* requirements apply, it means you must submit to us *proof* that you're insurable, and we must approve your *proof* in writing before your insurance, or the specified part becomes effective.

We require *proof* as follows:

CGP-3-R-SCH-90 B265.0444

All Options

We require *proof* before an *employee* switches from his or her current *plan* of voluntary accidental death and dismemberment insurance to a *plan* which provides greater benefits.

CGP-3-R-SCH-90 B265.0860

All Options

Dependent Optional Term Life Insurance

Dependent Optional Life Enrollment Period

You may choose one of the plans of dependent spouse optional term life insurance, and one of the plans of dependent child optional term life insurance shown below. You may only be insured under one spouse plan and one child plan at a time. You must notify the employer of your elections and pay the required premium.

You may switch to other plans of benefits at any time, subject to any of this plan's proof of insurability requirements. You must notify the employer of any desired switch.

CGP-3-R-SCH-90 B265.0662

All Options

Your Optional Dependent Spouse Term Life Insurance Amount

Plan A

You may elect amounts of optional dependent spouse term life insurance in increments of $5,000.00, but the amount may not be less than $5,000.00 and may not exceed $250,000.00.

CGP-3-R-SCH-90 B265.0505

All Options

Your Optional Dependent Child Insurance Amount

Plan A

Child's Age At Death	Benefit Amount
At least 14 days but less than 6 months	$ 1,000.00
At least 6 months but less than 26 years	$ 1,000.00
At least 26 years but less than 26 years if a full-time student	$ 1,000.00

CGP-3-R-SCH-90 B265.0655

All Options

Your Optional Dependent Child Insurance Amount

Plan B

Child's Age At Death	Benefit Amount
At least 14 days but less than 6 months	$ 5,000.00
At least 6 months but less than 26 years	$ 5,000.00
At least 26 years but less than 26 years if a full-time student	$ 5,000.00

CGP-3-R-SCH-90 B265.0655

All Options

Your Optional Dependent Child Insurance Amount

Plan C

Child's Age At Death	Benefit Amount
At least 14 days but less than 6 months	$ 10,000.00
At least 6 months but less than 26 years	$ 10,000.00
At least 26 years but less than 26 years if a full-time student	$ 10,000.00

CGP-3-R-SCH-90 B265.0655

All Options

In no event may the insurance amount of a dependent spouse exceed 50% of the insurance amount of an employee.

CGP-3-R-SCH-90 B265.4308

All Options

In no event may the insurance amount of a dependent child exceed 100% of the insurance amount of an employee.

CGP-3-R-SCH-90 B265.4304

All Options

Proof of Insurability Requirements

Proof of insurability requirements apply to your dependent optional term life insurance. Such requirements may apply to the full benefits amount or just part of them. When proof of insurability requirements apply, it means you must submit to us proof that a dependent is insurable, and we must approve the proof in writing before the insurance, or the specified part becomes effective.

We require proof as follows:

CGP-3-R-SCH-90 B265.0536

All Options

We require proof before you switch from your current increment of dependent optional term life insurance to an increment which provides a greater amount of insurance.

CGP-3-R-SCH-90 B265.0734

All Options

We require proof before we will insure any spouse who is enrolled for dependent optional term life insurance after the time allowed for enrolling as specified in this plan.

CGP-3-R-SCH-90 B265.0540

All Options

We require proof for any increase in the amount of dependent optional term life insurance with respect to a dependent spouse.

CGP-3-R-SCH-90 B265.0863

All Options

We require proof for any amount of dependent optional term life insurance in excess of $ 50,000.00 with respect to your dependent spouse.

CGP-3-R-SCH-90 B265.0542

All Options

We require proof for any amount of dependent optional term life insurance in excess of $5,000.00 with respect to your dependent spouse, if your dependent spouse's scheduled dependent optional term life effective date is after he or she reaches age 65.

CGP-3-R-SCH-90 B265.0864

All Options

We require proof before we will insure any child who is enrolled for dependent optional term life insurance after the time allowed for enrolling as specified in this plan.

CGP-3-R-SCH-90 B265.0549

All Options

We require proof for any increase in the amount of dependent optional term life insurance with respect to a dependent child.

CGP-3-R-SCH-90 B265.0867

All Options

We require proof for any amount of dependent optional term life insurance in excess of $ 10,000.00 with respect to your dependent child(ren).

CGP-3-R-SCH-90 B265.0551

LIFE INSURANCE

B270.0070

All Options

Your Group Term Life Insurance

Basic Life Benefit If you die while insured for this benefit, we'll pay your beneficiary the amount shown in the schedule.

Proof of Death We'll pay this insurance as soon as we receive written proof of death. This should be sent to us as soon as possible.

Your Beneficiary You decide who gets this insurance if you die. You should have named your beneficiary on your enrollment form. You can change your beneficiary at any time by giving your *employer* written notice, unless you've assigned this insurance. But the change won't take effect until your *employer* gives you written confirmation of the change.

If you named more than one person, but didn't tell us what their shares should be, they'll share equally. If someone you named dies before you do, his share will be divided equally by the beneficiaries still alive, unless you've told us otherwise.

If there is no beneficiary when you die, we'll pay the insurance to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; or (e) your brothers and sisters.

Assigning Your Life Insurance If you assign this insurance, you permanently transfer all your rights under this insurance to the assignee. Only one of the following can be an assignee: (a) your spouse; (b) one of your parents or grandparents; (c) one of your children or grandchildren; (d) one of your brothers or sisters; or (e) the trustee(s) of a trust set up for the benefit of one or more of these relatives.

We suggest you speak to your lawyer before you make any assignment. If you decide you want to assign this insurance, ask your *employer* for details or write to us.

Payment to a Minor or Incompetent If your beneficiary is a minor or incompetent, we have the option of paying this insurance in monthly installments. We would pay them to the person who cares for and supports your beneficiary.

Settlement Option If you or your beneficiary ask us, we'll pay all or part of this insurance in installments. Any request must be made to us in writing. The amounts of the installments and how they would be paid depend on what we offer at the time the request is made.

CGP-3-R-LB-90 B270.0113

Your Optional Group Term Life Insurance

Life Benefit Subject to the limitations and exclusions below, if you die while insured for this benefit, we'll pay your beneficiary the amount shown in the schedule for the plan of benefits you have elected. Your life benefit may be subject to reductions based on your age. These reductions are also shown in the schedule. Your benefit amount, a portion thereof, or increases in such amount may not become effective until you submit *proof of insurability* to us, and we approve it in writing. These requirements are also shown in the schedule.

Proof of Death Subject to all of the terms of this *plan,* we'll pay this insurance as soon as we receive written proof of death which is acceptable to us. This should be sent to us as soon as possible.

Suicide Exclusion We pay no benefits if your death is due to suicide, if such death occurs within two years from your employee optional group term life insurance effective date under this *plan.* Also, we pay no increased benefit amount if your death is due to suicide, if such death occurs within two years from the effective date of the increase.

Seatbelt and Airbag Benefits If you die as a direct result of an automobile accident while properly wearing a seatbelt, we will increase your benefit amount by $10,000.00. And if you die as a direct result of an automobile accident while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag, we'll increase your benefit amount by an additional $5,000.00, for a total increase of $15,000.00.

Your Beneficiary You decide who gets this insurance if you die. You should have named your beneficiary on your enrollment form. You can change your beneficiary at any time by giving your employer written notice, unless you've assigned this insurance. But the change won't take effect until your employer gives you written confirmation of the change.

If you named more than one person, but didn't tell us what their shares should be, they'll share equally. If someone you named dies before you do, his or her share will be divided equally by the beneficiaries still alive, unless you've told us otherwise.

If there is no beneficiary when you die, we'll pay the insurance to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; or (e) your brothers and sisters.

Assigning Your Life Insurance If you assign this insurance, you permanently transfer all your rights under this insurance to the assignee. Only one of the following can be an assignee: (a) your spouse; (b) one of your parents or grandparents; (c) one of your children or grandchildren; (d) one of your brothers or sisters; or (e) the trustee(s) of a trust set up for the benefit of one or more of these relatives.

We will recognize an assignee as the owner of the rights assigned only if: (a) the assignment is in writing and signed by you; and (b) a signed or certified copy of the written assignment has been received and approved by us.

We will not be responsible for legal, tax or other effects of any assignment, or for any benefits we pay under this *plan* before we receive and approve any assignment.

We suggest you speak to a lawyer before you make any assignment. If you decide you want to assign this insurance, write to us for details.

Payment to a Minor or Incompetent

If your beneficiary is a minor or incompetent, we have the option of paying this insurance in monthly installments. We would pay them to the person who cares for and supports your beneficiary.

Payment of Funeral or Last Illness Expense

We have the option of paying up to $500.00 of this insurance to any person who incurs expenses for your funeral or last illness.

Settlement Option

If you or your beneficiary asks us, we'll pay all or part of this insurance in installments. Any request must be made to us in writing. The amounts of the installments and how they would be paid depend on what we offer at the time the request is made.

CGP-3-R-EOPT-96 B273.0353

All Options

Portability Privilege

Applicability

This provision applies only to this *plan's* employee and dependent Optional group term life insurance. It does not apply to supplemental life insurance, if any is included in this *plan.* And it does not apply to Accidental Death and Dismemberment with Catastrophic Loss Insurance.

Important Restriction

You may not elect a portable certificate of coverage unless you have been covered by this group *plan,* or the one it replaced, for employee Optional group term life insurance for at least three consecutive months prior to the date your coverage under this *plan* ends.

Portability Of Optional Group Term Life Insurance

You may elect to continue all or part of your employee Optional group term life insurance and dependent Optional group term life insurance, by choosing a portable certificate of coverage, subject to the following terms.

You may port your coverage if coverage under this *plan* ends because you: (a) have terminated employment; or (b) stop being a member of an eligible class of employees.

You may not port your coverage or coverage for any of your dependents, if you: (a) have reached your 70th birthday on the day coverage under this *plan* ends; or (b) are eligible for this *plan's* Optional Group Term Life Insurance Extended Life Benefit.

You may not port your coverage or coverage for any of your dependents if coverage under this plan ends due to: (a) failure to pay any required premium; or (b) the end of this group *plan.*

You may port: (a) the full amount(s) of your Optional term life insurance as of the day your coverage under this *plan* ends, or (b) 50% of such amount, if such amount under this *plan* is at least $50,000.00.

You may port: (a) the full amount(s) of your dependent Optional term life insurance as of the day your coverage under this *plan* ends; or (b) 50% of such amount(s), if: (i) your dependent spouse amount under this *plan* is at least $20,000.00; and (ii) your dependent child amount under this *plan* is at least $4,000.00. However, if you port the full amount of your insurance, any dependent amount(s) ported must be a full amount. And, if you elect to port 50% of your insurance, any dependent amount(s) ported must be 50% of such amount(s).

You may port: (a) your insurance only; (b) your insurance and insurance of your covered spouse; (c) your insurance and the insurance of all of your covered dependents; or (d) if you are a single parent, your insurance and the insurance of all of your covered dependent children. No other combinations will be allowed.

To be eligible to port, a dependent must be insured as of the day your coverage under this *plan* ends.

If You Die While Insured

If you die while insured for dependent Optional term life insurance, your spouse may port the insurance of your dependents as described above. But, your spouse and dependents must be insured on the date of death. No dependents will be allowed to port if: (a) there is no surviving spouse; or (b) your surviving spouse has reached his or her 70th birthday on the day you die.

The Portable Certificate Of Coverage

You or your surviving spouse can port to a portable certificate of coverage. The certificate provides group term insurance. It does not provide any: (a) accidental death and dismemberment benefits: (b) income replacement benefits; or (c) extended life benefits or waiver of premium privileges. The benefits provided by the portable certificate of coverage may not be the same as the benefits of this group *plan.*

The premium for the portable certificate of coverage will be based on: (a) your and/or your dependent's rate class under this plan; and (b) your or your surviving spouse's age bracket as shown in the Optional Life Portability Coverage Premium Notice.

How To Port

To get a portable certificate of coverage, you or your surviving spouse must: (a) apply to us in writing; and (b) pay the required premium. You have 31 days from the date your coverage under this *plan* ends to do this. We won't ask for proof that you are insurable.

Defined Term

As used in this provision, the term "port" means to choose a portable certificate of coverage which provides group term life insurance.

CGP-3-R-LP-00 B273.0731

All Options

Information About Conversion and Portability

No covered person is allowed to convert his or her coverage, and elect a portable certificate of coverage at the same time. If a situation arises in which a covered person would be eligible to both convert and port, he or she may only exercise one of these privileges. A covered person may never be insured under both a converted policy and a portable certificate of coverage at the same time. The covered person should read his or her plan, as well as any related materials carefully before making an election.

CGP-3-R-LPN-95 B270.0326

All Options

THE FOLLOWING PROVISION APPLIES TO YOUR BASIC TERM LIFE INSURANCE:

B275.0076

All Options

Converting This Group Term Life Insurance

If Employment or Eligibility Ends

Your group life insurance ends if: (a) your employment ends; or (b) you stop being a member of an eligible class of employees. If either happens, you can convert your group life insurance to an individual life insurance policy. Conversion choices are based on your disability status.

If you are not disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium", you can convert to a permanent life insurance policy. You can convert the amount for which you were covered under this plan, less any group life benefits you become eligible for in the 31 days after this insurance ends.

If you: (a) are disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium"; and (b) have not yet been approved for the Extended Life Benefit, you can convert to: (a) a permanent life insurance policy; or (b) an interim term insurance policy, as explained in the section labeled "Interim Term Insurance". You can convert the full amount for which you were covered under this plan.

If you are later approved for the Extended Life Benefit, then the converted policy, if any, is cancelled as of our approval date.

If The Group Plan Ends or Group Life Insurance Is Dropped

Your group life insurance also ends if: (a) this group plan ends; or (b) life insurance is dropped from the group plan for all employees or for your class. If either happens, you may be eligible to convert as explained below. Conversion choices are based on your disability status.

If you: (a) are not disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium", when this coverage ends; and (b) you have been insured by a Guardian group life plan for at least five years, you can convert to a permanent life insurance policy. But, the amount you can convert is limited to the lesser of: (a) $2,000.00; or (b) the amount of your insurance under this plan, less any group life benefits you become eligible for in the 31 days after this insurance ends.

If you: (a) are disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium"; and (b) have not yet been approved for the Extended Life Benefit, you can convert to: (a) a permanent life insurance policy; or (b) an interim term insurance policy. You can convert the full amount for which you were covered under this plan.

If you are later approved for the Extended Life Benefit, then the converted policy, if any, is cancelled as of our approval date.

The Converted Policy

The premium for the converted policy will be based on your age on the converted policy's effective date. The converted policy will start at the end of the period allowed for conversion. The converted policy does not include disability or dismemberment benefits.

Interim Term Insurance

If you: (a) are disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium"; and (b) have not yet been approved for the Extended Life Benefit, you have the option to convert your coverage to an individual term life insurance policy. The individual term policy requires lower premiums than an individual permanent insurance policy.

This Interim term policy is available for only one year from the date you become disabled. During this year, if you are approved for the Extended Life Benefit, the interim term insurance is cancelled, as of our approval date. If, after one year, you have not been approved for the Extended Life Benefit, you must convert to an individual permanent life insurance policy, or coverage will end. Premiums for the individual permanent life insurance policy will be based on your age as of the date you convert from the interim term insurance policy.

How and When to Convert

To get a converted policy, you must apply to us in writing and pay the required premium. You have 31 days after your group life insurance ends to do this. We won't ask for proof that you are insurable.

Death During the Conversion Period

If you die in the 31 days allowed for conversion, we'll pay your beneficiary the amount you could have converted. We'll pay whether or not you applied for conversion.

Notice of Conversion Right

If you are entitled to obtain a converted policy under this section, full compliance with this provision for Notice of Conversion Right will be satisfied by written notice: (a) given to you by the employer; (b) mailed to you by the employer at your last known address; or (c) mailed to you by us at your last known address that is supplied to us by the employer.

This notice should be given at least 15 days before the end of the 31 day period allowed for conversion as described in "How and When to Convert." If the notice is not given at least 15 days before the end of such period, you will have an additional period of 25 days from the date notice is given to apply for the converted policy and pay the required premium. But, in no event shall the additional period extend more than 60 days beyond the 31 day period allowed for conversion as described above.

CGP-3-R-LCONV-99-CA B275.0217

All Options

THE FOLLOWING PROVISION APPLIES TO YOUR OPTIONAL GROUP TERM LIFE INSURANCE:

B275.0077

All Options

Converting This Group Term Life Insurance

If Employment or Eligibility Ends

Your group life insurance ends if: (a) your employment ends; or (b) you stop being a member of an eligible class of employees. If either happens, you can convert your group life insurance to an individual life insurance policy. Conversion choices are based on your disability status.

If you are not disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium", you can convert to a permanent life insurance policy. You can convert the amount for which you were covered under this plan, less any group life benefits you become eligible for in the 31 days after this insurance ends.

If you: (a) are disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium"; and (b) have not yet been approved for the Extended Life Benefit, you can convert to: (a) a permanent life insurance policy; or (b) an interim term insurance policy, as explained in the section labeled "Interim Term Insurance". You can convert the full amount for which you were covered under this plan.

If you are later approved for the Extended Life Benefit, then the converted policy, if any, is cancelled as of our approval date.

If The Group Plan Ends or Group Life Insurance Is Dropped

Your group life insurance also ends if: (a) this group plan ends; or (b) life insurance is dropped from the group plan for all employees or for your class. If either happens, you may be eligible to convert as explained below. Conversion choices are based on your disability status.

If you: (a) are not disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium", when this coverage ends; and (b) you have been insured by a Guardian group life plan for at least five years, you can convert to a permanent life insurance policy. But, the amount you can convert is limited to the lesser of: (a) $2,000.00; or (b) the amount of your insurance under this plan, less any group life benefits you become eligible for in the 31 days after this insurance ends.

If you: (a) are disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium"; and (b) have not yet been approved for the Extended Life Benefit, you can convert to: (a) a permanent life insurance policy; or (b) an interim term insurance policy. You can convert the full amount for which you were covered under this plan.

If you are later approved for the Extended Life Benefit, then the converted policy, if any, is cancelled as of our approval date.

The Converted Policy

The premium for the converted policy will be based on your age on the converted policy's effective date. The converted policy will start at the end of the period allowed for conversion. The converted policy does not include disability or dismemberment benefits.

Interim Term Insurance

If you: (a) are disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium"; and (b) have not yet been approved for the Extended Life Benefit, you have the option to convert your coverage to an individual term life insurance policy. The individual term policy requires lower premiums than an individual permanent insurance policy.

This Interim term policy is available for only one year from the date you become disabled. During this year, if you are approved for the Extended Life Benefit, the interim term insurance is cancelled, as of our approval date. If, after one year, you have not been approved for the Extended Life Benefit, you must convert to an individual permanent life insurance policy, or coverage will end. Premiums for the individual permanent life insurance policy will be based on your age as of the date you convert from the interim term insurance policy.

How and When to Convert

To get a converted policy, you must apply to us in writing and pay the required premium. You have 31 days after your group life insurance ends to do this. We won't ask for proof that you are insurable.

Death During the Conversion Period

If you die in the 31 days allowed for conversion, we'll pay your beneficiary the amount you could have converted. We'll pay whether or not you applied for conversion.

Notice of Conversion Right

If you are entitled to obtain a converted policy under this section, full compliance with this provision for Notice of Conversion Right will be satisfied by written notice: (a) given to you by the employer; (b) mailed to you by the employer at your last known address; or (c) mailed to you by us at your last known address that is supplied to us by the employer.

This notice should be given at least 15 days before the end of the 31 day period allowed for conversion as described in "How and When to Convert." If the notice is not given at least 15 days before the end of such period, you will have an additional period of 25 days from the date notice is given to apply for the converted policy and pay the required premium. But, in no event shall the additional period extend more than 60 days beyond the 31 day period allowed for conversion as described above.

CGP-3-R-LCONV-99-CA B275.0218

All Options

Your Accelerated Life Benefit

IMPORTANT NOTICE: USE OF THE BENEFIT PROVIDED BY THIS SECTION MAY HAVE TAX IMPLICATIONS AND MAY AFFECT GOVERNMENT BENEFITS OR CREDITORS. YOU SHOULD CONSULT WITH YOUR TAX OR FINANCIAL ADVISOR BEFORE APPLYING FOR THIS BENEFIT.

PLEASE NOTE: THE AMOUNT OF GROUP TERM LIFE INSURANCE IS PERMANENTLY REDUCED BY THE GROSS AMOUNT OF THE ACCELERATED LIFE BENEFIT PAID TO YOU.

Accelerated Life Benefit

If you have a medical condition that is expected to result in your death within 6 months, you may apply for an Accelerated Life Benefit. An Accelerated Life Benefit is a payment of part of your group term life insurance made to you before you die.

We subtract the gross amount paid to you as an Accelerated Life Benefit from the amount of your group term life insurance under this plan. The remaining amount of your group term life insurance is permanently reduced by the gross amount paid to you.

By "group term life insurance" we mean any Employee Basic Group Term Life Insurance for which you are insured under this plan. "Group term life insurance" does not mean Accidental Death and Dismemberment Benefits, any insurance provided under this plan for covered persons other than you or any scheduled increase in the amount of any Employee Group Term Life Insurance that is due within the 6 month period after the date you apply for the Accelerated Life Benefit.

By "gross amount" we mean the amount of an Accelerated Life Benefit elected by you, before the discount and the processing fee are subtracted.

For the purposes of this provision, "terminal condition" means a medical condition that is expected to result in your death within 6 months.

You may use the Accelerated Life Benefit in any way you choose. But you may receive only one Accelerated Life Benefit during your lifetime. If you live longer than 6 months, or if you recover from the condition, the benefit does not have to be repaid. But the amount of this benefit is not restored to your remaining group term life insurance. And you may not receive another Accelerated Life Benefit if you have a relapse or develop another terminal condition.

Maximum Benefit Amount

The amount of the Accelerated Life Benefit for which you may apply is based on the amount of group term life insurance for which you are insured on the day before you apply for the benefit. The minimum benefit amount is the lesser of: (a) $10,000.00; or (b) 75% of the inforce amount. The maximum benefit amount is the lesser of: (a) $500,000.00; or (b) 75% of the inforce amount.

Discount

The amount for which you apply is discounted to the present value in 6 months from the date the benefit is paid, based on the maximum adjustable policy loan interest rate permitted in the state in which your employer is located.

A detailed statement of the method of computing the amount of the Accelerated Life Benefit is filed with each state insurance department. This statement is available from The Guardian upon request.

Processing Fee

A fee of up to $150.00 may also be required for the administrative cost of evaluating and processing your Accelerated Life Benefit. This fee is deducted from the amount of the Accelerated Life Benefit paid to you.

Payment of An Accelerated Life Benefit

If we approve your application for an Accelerated Life Benefit, we pay the amount you have elected, less the discount and the processing fee.We pay the benefit to you in one lump sum. And what we pay is subject to all of the other terms of this plan.

How And When To Apply

To receive the Accelerated Life Benefit, you must send us written proof from a licensed doctor who is operating within the scope of his or her license that your medical condition is expected to result in your death within 6 months of the date of the written medical proof. We must approve such proof in writing before the Accelerated Life Benefit will be paid.

We can have you examined by a doctor of our choice to verify the terminal condition. We'll pay the cost of such examination. We will not pay the Accelerated Life Benefit if our doctor does not verify the terminal condition.

If we approve you to receive an Accelerated Life Benefit, we give you a statement which shows: (a) the amount of the maximum Accelerated Life Benefit for which you are eligible; and (b) the amount by which your group term life insurance will be reduced if you elect to receive the maximum Accelerated Life Benefit; and (c) the amount of the processing fee.

Even if you are receiving an Extended Life Benefit under this plan, you can still apply for an Accelerated Life Benefit. However, once you convert your group term life insurance, the terms of the converted life policy will apply. Any amount to which you could otherwise convert is permanently reduced by the gross amount of the Accelerated Life Benefit paid to you.

Please read "Your Remaining Group Term Life Insurance" provision for restrictions that may apply.

If You Have Assigned Your Group Term Life Insurance

If you have already assigned your group term life insurance, according to the terms of this plan, you can't apply for an Accelerated Life Benefit.

CGP-3-R-EALB-95 B275.0021

All Options

If You Are Incompetent

If you are determined to be legally incompetent, the person the court appoints to handle your legal affairs may apply for the Accelerated Life Benefit for you.

Your Remaining Group Term Life Insurance

The remaining amount of group term life insurance for which you are covered after receiving an Accelerated Life Benefit payment is subject to any increases or cutbacks that would otherwise apply to your insurance. Applicable cutbacks are applied to the amount of group term life insurance for which you are insured on the day before you apply for the Accelerated Life Benefit.

The premium cost of your remaining coverage is based on the amount of group term life insurance for which you are insured on the day before you apply for the Accelerated Life Benefit.

You may be required to provide proof of insurability for increased amounts. If you are, we must approve that proof in writing before you are covered for the new amount.

The total amount of group term life insurance your beneficiary would otherwise receive upon your death is reduced by the gross amount of the Accelerated Life Benefit paid to you.

If you die after electing the Accelerated Life Benefit, but before we send the benefit to you, your beneficiary will receive the amount of the group term life insurance for which you are insured on the day before you apply for the Accelerated Life Benefit.

Restrictions

We will not pay an Accelerated Life Benefit to you if you:

- are required by law to use the payment to meet the claims of creditors, whether or not you are in bankruptcy; or
- are required by court order to pay all or part of the benefit to another person; or
- are required by a government agency to use the payment to apply for, to receive or to maintain a governmental benefit or entitlement; or
- lose your coverage under the group plan for any reason after you elect the Accelerated Life Benefit but before we pay such benefit to you.

CGP-3-R-EALB-95-1 B270.0322

Your Accelerated Life Benefit

IMPORTANT NOTICE: USE OF THE BENEFIT PROVIDED BY THIS SECTION MAY HAVE TAX IMPLICATIONS AND MAY AFFECT GOVERNMENT BENEFITS OR CREDITORS. YOU SHOULD CONSULT WITH YOUR TAX OR FINANCIAL ADVISOR BEFORE APPLYING FOR THIS BENEFIT.

PLEASE NOTE: THE AMOUNT OF GROUP TERM LIFE INSURANCE IS PERMANENTLY REDUCED BY THE GROSS AMOUNT OF THE ACCELERATED LIFE BENEFIT PAID TO YOU.

Accelerated Life Benefit

If you have a medical condition that is expected to result in your death within 6 months, you may apply for an Accelerated Life Benefit. An Accelerated Life Benefit is a payment of part of your group term life insurance made to you before you die.

We subtract the gross amount paid to you as an Accelerated Life Benefit from the amount of your group term life insurance under this plan. The remaining amount of your group term life insurance is permanently reduced by the gross amount paid to you.

By "group term life insurance" we mean any Employee Optional Group Term Life Insurance for which you are insured under this plan. "Group term life insurance" does not mean Accidental Death and Dismemberment Benefits, any insurance provided under this plan for covered persons other than you or any scheduled increase in the amount of any Employee Group Term Life Insurance that is due within the 6 month period after the date you apply for the Accelerated Life Benefit.

By "gross amount" we mean the amount of an Accelerated Life Benefit elected by you, before the discount and the processing fee are subtracted.

For the purposes of this provision, "terminal condition" means a medical condition that is expected to result in your death within 6 months.

You may use the Accelerated Life Benefit in any way you choose. But you may receive only one Accelerated Life Benefit during your lifetime. If you live longer than 6 months, or if you recover from the condition, the benefit does not have to be repaid. But the amount of this benefit is not restored to your remaining group term life insurance. And you may not receive another Accelerated Life Benefit if you have a relapse or develop another terminal condition.

Maximum Benefit Amount

The amount of the Accelerated Life Benefit for which you may apply is based on the amount of group term life insurance for which you are insured on the day before you apply for the benefit. The minimum benefit amount is the lesser of: (a) $10,000.00; or (b) 50% of the inforce amount. The maximum benefit amount is the lesser of: (a) $250,000.00; or (b) 50% of the inforce amount.

Discount

The amount for which you apply is discounted to the present value in 6 months from the date the benefit is paid, based on the maximum adjustable policy loan interest rate permitted in the state in which your employer is located.

A detailed statement of the method of computing the amount of the Accelerated Life Benefit is filed with each state insurance department. This statement is available from The Guardian upon request.

Processing Fee

A fee of up to $150.00 may also be required for the administrative cost of evaluating and processing your Accelerated Life Benefit. This fee is deducted from the amount of the Accelerated Life Benefit paid to you.

Payment of An Accelerated Life Benefit

If we approve your application for an Accelerated Life Benefit, we pay the amount you have elected, less the discount and the processing fee.We pay the benefit to you in one lump sum. And what we pay is subject to all of the other terms of this plan.

How And When To Apply

To receive the Accelerated Life Benefit, you must send us written proof from a licensed doctor who is operating within the scope of his or her license that your medical condition is expected to result in your death within 6 months of the date of the written medical proof. We must approve such proof in writing before the Accelerated Life Benefit will be paid.

We can have you examined by a doctor of our choice to verify the terminal condition. We'll pay the cost of such examination. We will not pay the Accelerated Life Benefit if our doctor does not verify the terminal condition.

If we approve you to receive an Accelerated Life Benefit, we give you a statement which shows: (a) the amount of the maximum Accelerated Life Benefit for which you are eligible; and (b) the amount by which your group term life insurance will be reduced if you elect to receive the maximum Accelerated Life Benefit; and (c) the amount of the processing fee.

Even if you are receiving an Extended Life Benefit under this plan, you can still apply for an Accelerated Life Benefit. However, once you convert your group term life insurance, the terms of the converted life policy will apply. Any amount to which you could otherwise convert is permanently reduced by the gross amount of the Accelerated Life Benefit paid to you.

Please read "Your Remaining Group Term Life Insurance" provision for restrictions that may apply.

If You Have Assigned Your Group Term Life Insurance

If you have already assigned your group term life insurance, according to the terms of this plan, you can't apply for an Accelerated Life Benefit.

CGP-3-R-EALB-95 B275.0027

All Options

If You Are Incompetent

If you are determined to be legally incompetent, the person the court appoints to handle your legal affairs may apply for the Accelerated Life Benefit for you.

Your Remaining Group Term Life Insurance

The remaining amount of group term life insurance for which you are covered after receiving an Accelerated Life Benefit payment is subject to any increases or cutbacks that would otherwise apply to your insurance. Applicable cutbacks are applied to the amount of group term life insurance for which you are insured on the day before you apply for the Accelerated Life Benefit.

The premium cost of your remaining coverage is based on the amount of group term life insurance for which you are insured on the day before you apply for the Accelerated Life Benefit.

You may be required to provide proof of insurability for increased amounts. If you are, we must approve that proof in writing before you are covered for the new amount.

The total amount of group term life insurance your beneficiary would otherwise receive upon your death is reduced by the gross amount of the Accelerated Life Benefit paid to you.

If you die after electing the Accelerated Life Benefit, but before we send the benefit to you, your beneficiary will receive the amount of the group term life insurance for which you are insured on the day before you apply for the Accelerated Life Benefit.

Restrictions We will not pay an Accelerated Life Benefit to you if you:

- are required by law to use the payment to meet the claims of creditors, whether or not you are in bankruptcy; or
- are required by court order to pay all or part of the benefit to another person; or
- are required by a government agency to use the payment to apply for, to receive or to maintain a governmental benefit or entitlement; or
- lose your coverage under the group plan for any reason after you elect the Accelerated Life Benefit but before we pay such benefit to you.

All Options

Your Extended Life Benefit With Waiver Of Premium

Important Notice This section applies to your basic life benefit. But, it does not apply to your accidental death and dismemberment benefits; nor to any of your dependent's insurance under this group plan. In order to continue dependent basic life insurance, you must convert your dependent coverage to an individual permanent policy.

If You Are Disabled You are disabled if you meet the definition of total disability, as stated below. If you meet the requirements in the "How and When to Apply" provision, we'll extend your basic life insurance under this section without payment of premiums from you or the employer.

Total Disability or Totally Disabled means, due to sickness or injury, you are:

(a) not able to perform any work for wages or profit; and

(b) you are receiving regular doctor's care appropriate to the cause of disability.

How And When To Apply

To apply for this extension, you must submit satisfactory written medical proof of your total disability within one year of the onset of that disability. Any claim filed after one year from the onset of total disability will be denied, unless we receive written proof that: (a) you lacked the legal capacity to file the claim; or (b) it was not reasonably possible for you to file the claim.

Also, in order to be eligible for this extension, you must:

(a) become totally disabled before you reach age 60 and while insured by the group plan; and

(b) remain totally disabled for 09 continuous months.

You are encouraged to apply for this benefit immediately upon the onset of disability.

Continued Eligibility For Extended Life Benefit

We may require periodic written proof that you remain totally disabled to maintain this extension. This written proof of your continued disability and doctor's care must be provided to us within 30 days of the date we make each such request.

We can require that you take part in a medical assessment, with a medical professional of our choice, as often as we feel is reasonably necessary during the first two years we've extended your life benefits. But after two years, we can't have you examined more than once a year.

Until You've Been Approved For This Extended Life Benefit

Your life insurance under the group plan may end after you've become totally disabled, but before we've approved you for this extension. During this time period, you may either:

(a) continue group premium payments, including any portion which would have been paid by the employer until you are approved or declined for this extended life benefit; or

(b) convert to an individual permanent or term policy. Please read the section labeled "Converting This Group Term Life Insurance" for details on how to convert.

However, if this group plan terminates, and you are totally disabled and eligible, but not yet approved, for this extended benefit, you must convert to an individual permanent or term policy, and remain insured under such policy until you are approved by us for the extended benefit.

Converting does not stop you from claiming your rights under this section. But if you convert and we later approve you for this extended benefit, we'll cancel the converted policy as of our approval date. Once you are approved for this extended benefit, your group term life coverage will be reinstated at no further cost to you or the employer.

When This Extension Begins

Once approved by us, your extended benefit will be effective on the later of:

(a) 09 continuous months from the date active full-time service ends due to total disability; or

(b) the date we approve you for this benefit.

When This Extension Ends

Your extension will end on the earliest of:

(a) the date you are no longer disabled;

(b) the date we ask you to be examined by our doctor, and you refuse;

(c) the date you do not give us the proof of disability we require;

(d) the date you are no longer receiving regular doctor's care appropriate to the cause of disability; or

(e) the day before the date you reach age 65.

If the extension ends, and you are not insured by the group plan again as an active full-time employee, you can convert as if your employment just ended. Read the section labeled "Converting This Group Term Life Insurance".

If You Die While Covered By This Extension

If you die while covered by this extension we'll pay your beneficiary the amount for which you were covered as of your last day of active full-time work, subject to all reductions which would have applied had you stayed an active employee.

Proof Of Death

We'll pay as soon as we receive

(a) written proof of your death, that is acceptable to us; and

(b) medical proof that you were continuously disabled until your death. This must be sent within one year of your death.

Your Extended Life Benefit With Waiver Of Premium

Important Notice

This section applies to your optional life benefit. But, it does not apply to your accidental death and dismemberment benefits; nor to any of your dependent's insurance under this group plan. In order to continue dependent optional life insurance, you must convert your dependent coverage to an individual permanent policy.

If You Are Disabled

You are disabled if you meet the definition of total disability, as stated below. If you meet the requirements in the "How and When to Apply" provision, we'll extend your optional life insurance under this section without payment of premiums from you or the employer.

Total Disability or Totally Disabled means, due to sickness or injury, you are:

(a) not able to perform any work for wages or profit; and

(b) you are receiving regular doctor's care appropriate to the cause of disability.

How And When To Apply

To apply for this extension, you must submit satisfactory written medical proof of your total disability within one year of the onset of that disability. Any claim filed after one year from the onset of total disability will be denied, unless we receive written proof that: (a) you lacked the legal capacity to file the claim; or (b) it was not reasonably possible for you to file the claim.

Also, in order to be eligible for this extension, you must:

(a) become totally disabled before you reach age 60 and while insured by the group plan; and

(b) remain totally disabled for 09 continuous months.

You are encouraged to apply for this benefit immediately upon the onset of disability.

Continued Eligibility For Extended Life Benefit

We may require periodic written proof that you remain totally disabled to maintain this extension. This written proof of your continued disability and doctor's care must be provided to us within 30 days of the date we make each such request.

We can require that you take part in a medical assessment, with a medical professional of our choice, as often as we feel is reasonably necessary during the first two years we've extended your life benefits. But after two years, we can't have you examined more than once a year.

Until You've Been Approved For This Extended Life Benefit

Your life insurance under the group plan may end after you've become totally disabled, but before we've approved you for this extension. During this time period, you may either:

(a) continue group premium payments, including any portion which would have been paid by the employer until you are approved or declined for this extended life benefit; or

(b) convert to an individual permanent or term policy. Please read the section labeled "Converting This Group Term Life Insurance" for details on how to convert.

However, if this group plan terminates, and you are totally disabled and eligible, but not yet approved, for this extended benefit, you must convert to an individual permanent or term policy, and remain insured under such policy until you are approved by us for the extended benefit.

Converting does not stop you from claiming your rights under this section. But if you convert and we later approve you for this extended benefit, we'll cancel the converted policy as of our approval date. Once you are approved for this extended benefit, your group term life coverage will be reinstated at no further cost to you or the employer.

When This Extension Begins

Once approved by us, your extended benefit will be effective on the later of:

(a) 09 continuous months from the date active full-time service ends due to total disability; or

(b) the date we approve you for this benefit.

When This Extension Ends

Your extension will end on the earliest of:

(a) the date you are no longer disabled;

(b) the date we ask you to be examined by our doctor, and you refuse;

(c) the date you do not give us the proof of disability we require;

(d) the date you are no longer receiving regular doctor's care appropriate to the cause of disability; or

(e) the day before the date you reach age 65.

If the extension ends, and you are not insured by the group plan again as an active full-time employee, you can convert as if your employment just ended. Read the section labeled "Converting This Group Term Life Insurance".

If You Die While Covered By This Extension

If you die while covered by this extension we'll pay your beneficiary the amount for which you were covered as of your last day of active full-time work, subject to all reductions which would have applied had you stayed an active employee.

Proof Of Death

We'll pay as soon as we receive

(a) written proof of your death, that is acceptable to us; and

(b) medical proof that you were continuously disabled until your death. This must be sent within one year of your death.

Your Dependent Spouse and Child Optional Term Life Insurance

Your Choices

You may choose one of the plans of dependent spouse optional term life insurance, and one of the plans of dependent child optional term life insurance offered to you by your *employer*. These plans are shown in the schedule. However, you can only be insured under one spouse plan and one child plan at a time. You must notify your *employer* of your elections, and pay the required premium.

You may switch to other plans of benefits at any time, subject to any of this *plan's proof of insurability* requirements. You must notify your *employer* of any desired switch.

The Benefit

Subject to the limitations and exclusions shown below, if one of your dependents dies while insured for this benefit, we pay the amount shown in the schedule for the plan you have elected. We pay this in a lump sum when we receive written proof of death which is acceptable to us. Send the proof to us as soon as soon as possible.

We pay you, if you're living. If you're not, and the dependent was your child, we pay your spouse. If your spouse is not living, we pay the child's living brothers and sisters in equal shares. If there are none, we pay the child's estate. If the dependent was your spouse, we pay your spouse's estate.

Your Dependent Spouse and Child Optional Term Life Insurance (Cont.)

Suicide Exclusion

We pay no benefits if the dependent's death is due to suicide, if such death occurs within two years from the effective date of the dependent's optional term life insurance under this *plan.* Also, we pay no increased benefit amount if the dependent's death is due to suicide, if such death occurs within two years from the effective date of the increase.

Seatbelt and Airbag Benefits

If a dependent dies as a direct result of an automobile accident while properly wearing a seatbelt, we will increase the benefit amount by $5,000.00. And if a dependent dies as a direct result of an automobile accident while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag, we'll increase the benefit amount by an additional $2,500.00, for a total increase of $7,500.00.

Payment to a Minor or Incompetent

If the beneficiary is a minor or not competent, we have the right to pay in monthly installments. We would pay the person who cares for and supports the beneficiary. We completely discharge our liability for any amounts paid this way.

All Options

Converting This Dependent Term Life Insurance

If Your Group Life Insurance Ends or You Stop Being Eligible

Dependent term life insurance ends for all of your dependents when your group life insurance ends. Your insurance ends when: (a) your active full-time employment ends; (b) you stop being a member of a class of employees eligible for employee group life insurance; (c) your group life insurance is extended under the Extended Life Benefit provision; or (d) you die.

Dependent term life insurance also ends when you stop being a member of a class of employees eligible for dependent term life insurance.

If one of the above happens, each dependent who was insured may convert all or part of his or her insurance.

If This Plan Ends or Life Insurance is Dropped

Dependent term life insurance also ends for all of your dependents when this plan ends. And it ends if either employee or dependent term life insurance is dropped from this plan for all employees or for your class.

If one of the above happens, and your dependents have been insured by a Guardian group plan for at least five years, they can convert. But we limit the amount each dependent can convert to the lesser of: (a) $2,000.00; and (b) the amount of his or her insurance under this plan less any group life benefits for which he or she becomes eligible in the 31 days after this insurance ends.

If a Dependent Stops Being Eligible

A dependent's term life insurance ends when he or she stops being an eligible dependent as defined by this plan. If a dependent stops being eligible, that dependent can convert all or part of his or her insurance.

The Converted Policy

The dependent can convert to one of the individual life insurance policies we normally issue. That policy can't include disability benefits. And it can't be a term policy.

The premium for the converted policy will be based on: (a) the dependent's risk and rate class under this plan; and (b) the dependent's age when the converted policy takes effect. The converted policy takes effect at the end of the period allowed for conversion.

Write to us for details.

How and When to Convert

To get a converted policy, the dependent must apply to us in writing and pay the required premium. He or she has 31 days after his or her group insurance ends to do this. We won't ask for proof that he or she is insurable.

If the dependent is a minor or not competent, the person who cares for and supports the dependent may apply for him or her.

Death During the Conversion Period

If a dependent dies in the 31 days allowed for conversion, we pay the amount he or she could have converted, as stated above. We do this whether or not he or she applied for conversion.

Notice of Conversion Right:

If your dependent is entitled to obtain a converted policy under this section, full compliance with this provision for Notice of Conversion Right will be satisfied by written notice: (a) given to you by the employer; (b) mailed to you by the employer at your last known address; or (c) mailed to you by us at your last known address that is supplied to us by the employer.

The notice should be given at least 15 days before the end of the 31 day period allowed for conversion as described in "How and When to Convert." If the notice is not given at least 15 days before the end of such period, the dependent will have an additional period of 25 days from the date notice is given to apply for the converted policy and pay the required premium. But, in no event shall the additional period extend more than 60 days beyond the 31 day period allowed for conversion as described above.

CGP-3-R-DEPL-03-N-CA B295.0067

All Options

Your Basic Accidental Death And Dismemberment With Catastrophic Loss Benefits

The Benefit

We'll pay the benefits described below if you suffer an irreversible covered loss due to an accident that occurs while you are insured. The loss must be a direct result of the accident, independent of all other causes. And, it must occur within 365 days of the date of the accident.

Covered Losses

Benefits will be paid only for losses identified in the following table. The Insurance Amount is shown in the Schedule.

ACCIDENTAL DEATH AND DISMEMBERMENT

Covered Loss	Benefit
Loss of Life	100% of Insurance Amount
Loss of a hand	50% of Insurance Amount
Loss of a foot	50% of Insurance Amount
Loss of sight in one eye	50% of Insurance Amount
Loss of thumb and index finger of same hand	25% of Insurance Amount

CATASTROPHIC LOSS BENEFITS

Covered Loss	Benefit
Quadriplegia (total paralysis of upper and lower limbs, bilaterally)	100% of Insurance Amount
Loss of speech and hearing (both ears)	100% of Insurance Amount
Loss of cognitive function	100% of Insurance Amount
Comatose state, in excess of one month	100% of Insurance Amount
Hemiplegia (total paralysis of upper and lower limbs, unilaterally)	50% of Insurance Amount
Paraplegia (total paralysis of both lower limbs)	50% of Insurance Amount
Loss of speech or hearing (both ears)	50% of Insurance Amount

For covered multiple losses due to the same accident, we will pay 100% of the Insurance Amount. We won't pay more than 100% of the Insurance Amount for all losses due to the same accident, except under the Seatbelt and Airbag Benefit, and Repatriation Benefit provisions.

Loss of:

(a) cognitive function means a significant decline or loss in intellectual aptitude. Such loss must result from an accidental injury. It must be supported by clinical proof or standardized tests that precisely measure decline in the areas of: (i) short term memory; (ii) orientation to time, place and person; (iii) deductive or abstract reasoning; and (iv) judgement as it relates to awareness of safety.

(b) a hand or foot means it is completely cut off at or above the wrist or ankle.

(c) sight means the total and permanent loss of sight.

(d) speech or hearing means that speech or hearing is lost entirely.

Payment Of Benefits

For covered loss of life, we pay the beneficiary of your basic group term life insurance.

For all other covered losses, we pay you, if you are living. If not, we pay the beneficiary of your basic group term life insurance.

We pay all benefits in a lump sum, as soon as we receive proof of loss which is acceptable to us. This should be sent to us as soon as possible.

CGP-3-R-ADCL1-00 B310.1139

All Options

Seatbelt And Airbag Benefits

If you die as a direct result of a motor vehicle accident while properly wearing a seatbelt, we will increase your benefit by $10,000.00. And if you die as a direct result of a motor vehicle accident while both: (a) properly wearing a seatbelt; and (b) sitting in a seat equipped with an airbag; we'll increase your benefit by another $5,000.00, for a total increase of $15,000.00.

Repatriation Benefit

For covered loss of life due to an accident which occurs at least 75 miles from your home, we pay an extra sum. We pay up to $5,000.00 for costs to prepare and transport your body to a mortuary chosen by you or an authorized agent.

Exclusions

We won't pay for any loss caused directly or indirectly:

- by willful self-injury, suicide, or attempted suicide;
- by sickness, disease, mental infirmity, medical or surgical treatment;
- by your taking part in a riot or other civil disorder; or in the commission of or attempt to commit a felony;
- by travel on any type of aircraft if you are an instructor or crew member; or have any duties at all on that aircraft;
- by declared or undeclared war or act of war or armed aggression;
- while you are a member of any armed force;
- while you are a driver in a motor vehicle accident, if you do not hold a current and valid driver's license;
- by your legal intoxication; this includes, but is not limited to, your operation of a motor vehicle; or
- by your voluntary use of a controlled substance, unless: (1) it was prescribed for you by a doctor; and (2) it was used as prescribed. A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.

CGP-3-R-ADCL2-00 B310.1051

SPOUSAL EDUCATION AND RETRAINING BENEFIT

If you suffer a specified loss due to an accidental bodily injury, we will pay a spousal education and retraining benefit subject to all the terms below.

When And How The Spousal Education And Retraining Benefit Begins

We will pay a spousal education and retraining benefit when all of the following conditions are met:

(a) a benefit is payable under this plan's Employee Basic Accidental Death and Dismemberment with Catastrophic Loss (ADDCL) Benefit, due to a specified loss; and

(b) on the date of the accidental injury which results in the specified loss, you and your spouse share the same place of residence;

(c) we receive proof of the spouse's enrollment in an institute of higher learning. The spouse must: (i) be enrolled on the date of the accidental injury which results in the specified loss; or (ii) enroll within 12 months of this date.

Specified Loss means: (1) death; (2) a comatose state which lasts for a period in excess of one month; (3) spinal cord injury, resulting in: (a) quadriplegia; (b) paraplegia; or (c) hemiplegia; or (4) severe head injury resulting in loss of cognitive function. Loss of cognitive function means a significant decline or loss in intellectual aptitude. It must be supported by clinical proof or standardized tests that precisely measure decline in the areas of: (i) short term memory; (ii) orientation to time, place and person; (iii) deductive or abstract reasoning; and (iv) judgement as it relates to awareness of safety.

Institute of Higher Learning includes, but is not limited to: (a) universities; (b) colleges; (c) trade schools; and (d) professional schools. It does not include graduate level programs.

What We Pay

Subject to all the terms of this plan, the Spousal Education and Retraining Benefit per academic term is equal to the lesser of: (i) the spouse's net tuition expense for the term; (ii) 5% of the Employee Basic ADDCL Benefit paid as a result of the specified loss; and (iii) $2,500.00.

Tuition Expense means charges incurred for courses or lab fees. It does not include: (a) cost of books; (b) other related course materials; (c) student activity fees; or (d) room and board.

Net Tuition Expense means tuition expense less any scholarships or grants to which the spouse is entitled.

We pay this benefit to the person who has primary responsibility for these expenses.

This benefit is paid per academic term. Benefit duration is based on whether the spouse is enrolled in a part-time or full-time course of study. See the Employee Basic Accidental Death and Dismemberment Insurance Schedule.

Continued Eligibility For The Spousal Education And Retraining Benefit

We require periodic proof of the spouse's continued enrollment in an institute of higher learning. The spouse must maintain a grade point average of at least 2.0 on a 4.0 scale, or the equivalent. We also require proof, per academic term, of: (a) the spouse's tuition expenses; and (b) any scholarships and grants the spouse is entitled to.

When The Spousal Education And Retraining Benefit Ends

The spousal education and retraining benefit ends on the earliest of the following dates:

(a) the date the spouse is no longer enrolled in an institute of higher learning;

(b) the date the spouse fails to maintain a minimum grade point average as required above;

(c) the date the spouse fails to furnish proof as required above;

(d) the date the lifetime maximum benefit amount, shown in the schedule, is reached; and

(e) the date the maximum number of benefit payments, shown in the schedule, is reached.

CGP-3-R-ESED-00 B310.1054

All Options

DAY CARE EXPENSE BENEFIT

If you suffer a specified loss due to an accidental bodily injury, we will pay a Day Care Expense Benefit subject to all the terms below.

Eligibility For The Day Care Expense Benefit

This plan provides a day care expense benefit when all of the following conditions are met:

(a) a benefit is payable under this plan's Employee Basic Accidental Death and Dismemberment with Catastrophic Loss Benefit (ADDCL), due to a specified loss; and

(b) we receive proof of a qualified dependent's enrollment in a qualified day care program. Such enrollment must commence within 12 months of the date of the specified loss.

Specified Loss means: (1) death; (2) a comatose state which lasts for a period in excess of one month; (3) spinal cord injury, resulting in: (a) quadriplegia; (b) paraplegia; or (c) hemiplegia; or (4) severe head injury resulting in loss of cognitive function. Loss of cognitive function means a significant decline or loss in intellectual aptitude. It must be supported by clinical proof or standardized tests that precisely measure decline in the areas of: (i) short term memory; (ii) orientation to time, place and person; (iii) deductive or abstract reasoning; and (iv) judgement as it relates to awareness of safety.

Qualified Dependent: For purposes of the Day Care Expense Benefit a qualified dependent is: (a) your: (i) biological child; (ii) lawfully adopted child; (iii) stepchild; or (iv) any other child who is living with you in a regular parent-child relationship; (b) dependent upon you for main support and maintenance; and (c) under the age of seven on the date of the accidental injury which results in the specified loss.

Qualified Day Care Program: means a program of child care which: (i) is provided in a facility that is licensed as a day care center; or (ii) is operated by a licensed day care provider; and (iii) charges a fee for the care of children. A qualified day care program does not include child care provided by a parent, step-parent, grandparent, sibling, aunt or uncle.

What We Pay

Subject to all the terms of this plan, the Day Care Expense Benefit is equal to the lesser of: (i) $10,000 annually; or (ii) the actual annual day care expenses for all of your qualified dependents.

We pay this benefit quarterly, in arrears, upon receipt of proof of qualified day care expenses. Proof should be submitted within 30 days following the end of each calendar year quarter.

Payment will be made to the person who has primary responsibility for these expenses.

Continued Eligibility For The Day Care Expense Benefit

We require periodic proof that a qualified dependent remains enrolled in a qualified day care program. We require periodic proof of the qualified dependent's day care expenses.

When The Day Care Expense Benefit Ends

This plan's Day Care Expense Benefits end on the earliest of the following dates:

(a) the date the dependent is no longer qualified, as defined above;

(b) the date the dependent is no longer enrolled in a qualified day care program;

(c) the date we do not receive proof of qualified day care expenses, as required by this plan; and

(d) four years from the date the first day care expense benefit is paid.

All Options

DEPENDENT CHILD EDUCATION BENEFIT

If you suffer a specified loss due to an accidental bodily injury, we will pay an education benefit on behalf of a qualified dependent, subject to all the terms below.

When And How The Dependent Child Education Benefit Begins

We will pay a Dependent Child Education Benefit when all of the following conditions are met:

(a) A benefit is payable under this plan's Employee Basic Accidental Death and Dismemberment with Catastrophic Loss Benefit (ADDCL), due to a specified loss;

(b) We receive proof of a qualified dependent's enrollment in an institute of higher learning. The dependent must be a full-time student, as defined by the institute.

Specified Loss means: (1) death; (2) a comatose state which lasts for a period in excess of one month; (3) spinal cord injury which results in: (a) quadriplegia; (b) paraplegia; or (c) hemiplegia; or (4) severe head injury which results in loss of cognitive function. Loss of cognitive function means a significant decline or loss in intellectual aptitude. It must be supported by clinical proof or standardized tests that precisely measure decline in the areas of: (i) short term memory; (ii) orientation to time, place and person; (iii) deductive or abstract reasoning; and (iv) judgement as it relates to awareness of safety.

Qualified Dependent: To be qualified for the Dependent Child Education Benefit, a dependent must meet the following conditions. The dependent must be: (a) your: (i) biological child; (ii) lawfully adopted child; (iii) stepchild; or (iv) any other child who is living with you in a regular parent-child relationship; (b) unmarried; and (c) dependent upon you for main support and maintenance. On the date of the accidental injury which results in the specified loss, the dependent must be: (a) 22 years of age or younger; and (b) enrolled as a full-time student in an institute of higher learning; or (c) in the 12th grade, and enroll as a full-time student in an institute of higher learning within 12 months of this date. The dependent must maintain a grade point average of at least 2.0 on a 4.0 scale, or the equivalent.

Institute of Higher Learning includes, but is not limited to: (a) universities; (b) colleges; (c) trade schools; and (d) professional schools. It does not include graduate level programs.

What We Pay

Subject to all the terms of this plan, the Dependent Child Education Benefit per academic term is equal to the lesser of: (i) the qualified dependent's net tuition expense for the term; (ii) 5% of the Basic ADDCL Benefit paid as a result of the specified loss; or (iii) $2,500.00.

Tuition Expense means charges incurred for credit courses or lab fees. It does not include: (a) cost of books; (b) other related course materials; (c) student activity fees; or (d) room and board.

Net Tuition Expense means tuition expense less any scholarships or grants to which the dependent is entitled.

We pay this benefit per academic term for each qualified dependent.

We pay this benefit to the person who has primary responsibility for these expenses.

Continued Eligibility For Dependent Education Benefit

We require periodic proof that a dependent remains a qualified dependent, as defined above. We also require proof, per academic term, of: (a) the qualified dependent's tuition expenses; and (b) any scholarships and grants the dependent is entitled to.

When The Dependent Child Education Benefit Ends

A qualified dependent's Dependent Child Education Benefit ends on the earliest of the following dates:

(a) the date the dependent child is no longer a qualified dependent, as defined above;

(b) the date the dependent fails to furnish proof as required above;

(c) the date the lifetime maximum benefit amount, shown in the schedule, is reached;

(d) the date the maximum number of benefit payments, shown in the schedule, is reached; and

(e) the date the maximum benefit period, shown in the schedule, is reached.

CGP-3-R-EDCED-00 B310.1060

All Options

Your Voluntary Accidental Death And Dismemberment Benefits

The Choices You may elect to be insured for any of the plans of employee voluntary accidental death and dismemberment (ADD) insurance offered by the employer. These plans are shown in the schedule. However, you can only be insured under one plan at a time. You must notify the employer of your election and pay the required premium.

You may switch to another plan of benefits at any time, subject to any of this plan's proof of insurability requirements. You must notify the employer of any desired switch.

The Benefit We'll pay the benefits described below if you suffer an irreversible covered loss due to an accident that occurs while you are insured. The loss must be a direct result of the accident, independent of all other causes. And, it must occur within 90 days of the date of the accident.

Covered Losses Benefits will be paid according to the plan you have elected, only for losses identified in the following table. The Insurance Amount is shown in the Schedule.

ACCIDENTAL DEATH AND DISMEMBERMENT

Covered Loss	Benefit
Loss of Life	100% of Insurance Amount
Loss of a hand	50% of Insurance Amount
Loss of a foot	50% of Insurance Amount
Loss of sight in one eye	50% of Insurance Amount
Loss of thumb and index finger of same hand	25% of Insurance Amount

For covered multiple losses due to the same accident, we will pay 100% of the Insurance Amount. We won't pay more than 100% of the Insurance Amount for all losses due to the same accident.

Loss of:

(a) a hand or foot means it is completely cut off at or above the wrist or ankle.

(b) sight means the total and permanent loss of sight.

Payment Of Benefits

For covered loss of life, we pay the beneficiary described below.

For all other covered losses, we pay you, if you are living. If not, we pay the beneficiary described below.

We pay all benefits in a lump sum, as soon as we receive proof of loss which is acceptable to us. This should be sent to us as soon as possible.

The Beneficiary

You decide who gets this insurance if you die. You should have named a beneficiary on your enrollment form. You can change your beneficiary at any time by giving us notice, unless you have assigned insurance. But the change won't take effect until we give you confirmation of the change.

If you named more than one person, but didn't tell us what their shares should be, your insurance will be divided equally by the beneficiaries still alive, unless you tell us otherwise.

If there is no beneficiary when you die, we'll pay the insurance to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; or (e) your brothers and sisters.

CGP-3-R-ADCL1-00 B310.1219

All Options

Exclusions

We won't pay for any loss caused directly or indirectly:

- by willful self-injury, suicide, or attempted suicide;
- by sickness, disease, mental infirmity, medical or surgical treatment;
- by your taking part in a riot or other civil disorder; or in the commission of or attempt to commit a felony;
- by travel on any type of aircraft if you are an instructor or crew member; or have any duties at all on that aircraft;
- by declared or undeclared war or act of war or armed aggression;
- while you are a member of any armed force;

- while you are a driver in a motor vehicle accident, if you do not hold a current and valid driver's license;
- by your legal intoxication; this includes, but is not limited to, your operation of a motor vehicle; or
- by your voluntary use of a controlled substance, unless: (1) it was prescribed for you by a doctor; and (2) it was used as prescribed. A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.

CGP-3-R-ADCL2-00 B310.1239

ELIGIBILITY FOR DISABILITY COVERAGE

B329.0002

All Options

Employee Coverage

Eligible Employees To be eligible for employee coverage, you must be an active *full-time employee.* And you must belong to a class of *employees* covered by this *plan.*

Other Conditions You must:

(a) be legally working in the United States, or working outside of the United States for a United States based employer in a country or region approved by us.

(b) be regularly working at least the number of hours in the normal work week set by your *employer* (but not less than 30 hours per week), at:

(i) your *employer's* place of business;

(ii) some place where your *employer's* business requires you to travel; or

(iii) any other place you and your *employer* have agreed upon for performance of occupational duties.

Part or all of your insurance amounts may be subject to *proof* that you're insurable. Other parts of this coverage explain if and when we require *proof.* You won't be covered for any amount that requires such *proof* until you give the *proof* to us and we approve it in writing.

CGP-3-EC-90-1.0 B329.0886

All Options

When Your Coverage Starts

Employee benefits that don't require proof that you are insurable are scheduled to start on the effective date shown on the sticker attached to the inside front cover of this booklet.

Employee benefits that require such proof won't start until you send us the proof and we approve it in writing. Once we have approved it, the benefits are scheduled to start on the effective date shown in the endorsement section of your application. A copy of the approved application is furnished to you.

But you must be fully capable of performing the major duties of your regular occupation for your *employer* on a full-time basis at 12:01AM Standard Time for your place of residence on the scheduled effective date or dates. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are not fully capable of performing the major duties of your regular occupation on any date part of your insurance is scheduled to start we will postpone that part of your coverage. We will postpone that part of your coverage until the date you are so capable and are working your regular number of hours for one full day, with the expectation that you could do so for one full week.

Sometimes, the effective date shown on the sticker or in the endorsement is not a regularly scheduled work day. If the scheduled effective date falls: on a holiday; on a vacation day; on a non-scheduled work day; or during an approved leave of absence, not due to sickness or injury, of 90 days or less; and if you were performing the major duties of your regular occupation and working your regular number of hours on your last regularly scheduled work day, your coverage will start on the scheduled effective date. However, any coverage or part of coverage for which you must elect and pay all or part of the cost, will not start if you are on an approved leave and such coverage or part of coverage was not previously in force for you under a prior plan which this *plan* replaced.

All Options

When Your Coverage Ends

Your long term disability coverage ends on the date your active *full-time* service ends for any reason.

It also ends on the date you stop being a member of a class of *employees* eligible for insurance under this *plan,* or when this *plan* ends for all *employees.* And it ends when this *plan* is changed so that benefits for the class of *employees* to which you belong ends.

It ends on the date you are no longer working in the United States, or working outside of the United States for a United States based employer in a country or region approved by us.

If you are required to pay all or part of the cost of this coverage and you fail to do so, your coverage ends. It ends on the last day of the period for which you made the required payments, unless coverage ends earlier for other reasons.

However, if you are disabled, as defined by this *plan* when your active *full-time* service ends, coverage remains in force during: (a) the elimination period, subject to premium payment, if: (i) the disability is not excluded under the *plan;* and (ii) benefits are not excluded due to application of this *plan's* pre-existing condition provision; and (b) the period for which benefits are payable under the *plan.*

CGP-3-EC-90-3.0 B329.0933

All Options

Coverage During a Temporary Leave

If your active full-time service ends because you are disabled by pregnancy, childbirth or a related medical condition you may continue your coverage for up to four months during any twelve consecutive months.

Your employer may recover from you any premium paid if: 1) you fails to return from leave after four months; and 2) your failure to return is for a reason other that one of the following: (a) your taking leave under the Moore-Brown-Roberti Family Rights Act; (b) the continuation, recurrence, or onset of a health condition that entitles you to leave is beyond your control; or (c) if your employer is a state agency, the collective bargaining agreement will govern.

CGP-3-EC-90-3.0 B329.1132

All Options

An Employee's Right To Continue Group Long Term Disability Income Insurance During A Family Leave Of Absence

Important Notice

This section may not apply to an *employer's* plan. You must contact your *employer* to find out if your *employer* must allow for a leave of absence under federal law. In that case the section applies.

Continuation of Disability Coverage

Long term disability income coverage may be continued, under a uniform, non-discriminatory policy applicable to all employees. You must contact your *employer* to find out if you may continue this coverage.

If Your Group Insurance Would End

Group long term disability income insurance may normally end for an *employee* because he or she ceases work due to an approved leave of absence. But, the *employee* may continue his or her group coverage if the leave of absence has been granted: (a) to allow the *employee* to care for a seriously injured or ill spouse, child or parent; (b) after the birth or adoption of a child; (c) due to the *employee's* own serious health condition; or (d) because of any serious injury or illness arising out of the fact that a spouse, child, parent, or next of kin, who is a covered servicemember, of the *employee* is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation. The *employee* will be required to pay the same share of the premium as he or she paid before the leave of absence.

When Continuation Ends

Coverage may continue until the earliest of the following:

- The date you return to active work.
- In the case of a leave granted to you to care for a covered servicemember: The end of a total leave period of 26 weeks in one 12 month period. This 26 week total leave period applies to all leaves granted to you under this section for all reasons. If you take an additional leave of absence in a subsequent 12 month period, continued coverage will cease at the end of a total leave period of 12 weeks.
- In any other case: The end of a total leave period of 12 weeks in any 12 month period.
- The date on which your *Employer's Plan* is terminated or you are no longer eligible for coverage under this *Plan.*
- The end of the period for which the premium has been paid.

Definitions

As used in this section, the terms listed below have the meanings shown below:

- **Active Duty:** This term means duty under a call or order to active duty in the Armed Forces of the United States.
- **Contingency Operation:** This term means a military operation that: (a) is designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force; or (b) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law during a war or during a national emergency declared by the President or Congress.
- **Covered Servicemember:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness: (a), is undergoing medical treatment, recuperation, or therapy; (b) is otherwise in outpatient status; or (c) is otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means the nearest blood relative of the *employee.*

- **Outpatient Status:** This term means, with respect to a covered servicemember, that he or she is assigned to: (a) a military medical treatment facility as an outpatient; or (b) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.

- **Serious Injury Or Illness:** This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her office, grade, rank, or rating.

CGP-3-STD07-3.0 B329.1113

All Options

LONG TERM DISABILITY HIGHLIGHTS

SCHEDULE OF BENEFITS

This page provides a quick guide to some of the plan features about which people most often want to know. But it's not a complete description of your long term disability plan. Read the following pages carefully for a complete explanation of what we pay, limit, and exclude.

CGP-3-LTD07-HL-CA B380.3325

All Options

Own Occupation Period

The maximum payment period.

CGP-3-LTD07-HL-CA B380.3327

All Options

Elimination Period

For disability due to injury . . . . . 180 days

For disability due to sickness . . . . . 180 days

CGP-3-LTD07-HL-CA B380.3328

All Options

Maximum Payment Period

See the following table:

For a disability starting before the *employee* reaches age 60, the *maximum payment period* will last until the Social Security Normal Retirement Age as shown in the following table:

Employee's Year of Birth	Social Security Normal Retirement Age
Before 1938	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943-1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
After 1959	67

For a disability starting on or after the employee reaches age 60, the maximum payment period will be determined according to the following table:

Age When Disability Starts	Maximum Payment Period
Age 60	5.00 years
Age 61	4.00 years
Age 62	3.50 years
Age 63	3.00 years
Age 64	2.50 years
Age 65	2.00 years
Age 66	1.75 years
Age 67	1.50 years
Age 68	1.25 years
Age 69 or older	1.00 year

But if an employee whose disability starts after age 60 reaches the end of the maximum payment from this table before he reaches the Social Security Normal Retirement Age, we will extend his maximum payment period until he reaches Social Security Normal Retirement Age.

CGP-3-LTD07-HL-CA B380.3331

All Options

Maximum Monthly Benefit

66 2/3% of your *insured earnings,* rounded to the nearest $1.00, if not already a multiple thereof, limited to a maximum of $15,000.00.

NOTE: We integrate your *gross monthly benefit* with certain other income you may receive. Read all the terms of this *plan* to see what income we integrate with, and how.

CGP-3-LTD07-HL-CA B380.3338

All Options

Survivor Benefit

3 times the last monthly benefit after it is reduced by *disability earnings* you received.

CGP-3-LTD07-HL-CA B380.3389

LONG TERM DISABILITY INCOME INSURANCE

This insurance replaces part of your income if you become *disabled* due to a covered *sickness* or *injury.* What we pay is governed by all the terms of this *plan.*

All terms in italics are defined terms with special meanings. See the definitions section of this *plan.* Other terms with special meanings are defined where they are used.

Benefit Provisions

How Payments Start

To start getting payments from this *plan,* you must meet all of the conditions listed below:

(a) You must: (i) become *disabled* while insured by this *plan;* and (ii) remain *disabled* for this *plan's elimination period.*

(b) You must provide proof of loss, as described in this *plan's* Claim Provisions section. Benefits accrue as of the first day following the end of the *elimination period,* subject to all *plan* terms.

You can satisfy the *elimination period* while working, provided you are *disabled* as defined by this *plan.*

Waiver of Premium

We waive your premiums for this insurance and for short term disability insurance, if included in the *plan sponsor's* plan of insurance while you are entitled to receive a *monthly benefit* payment from this *plan.*

When Payments End

Your benefits from this *plan* will end on the earliest of the dates shown below:

(a) The date you are no longer *disabled.*

(b) The date you fail to unreasonably provide proof of loss as required by this *plan.*

(c) The date you earn the maximum earnings allowed while *disabled* under this *plan.*

(d) The date you have been outside the United States and/or Canada for more than 6 months in a 12 month period.

(e) The date you die.

(f) The end of the *maximum payment period.*

(g) The date no further benefits are payable under any provision in this *plan* that limits the *maximum payment period.*

(h) The date payments end in accord with a rehabilitation agreement. However, this date will not apply if the rehabilitation agreement is not fulfilled but you remain disabled in accord with the terms of the plan and the maximum payment period has not been reached.

All Options

Maximum Payment Period: The *maximum payment period* is the longest time that benefits are paid by this *plan* for a covered person's *disability.* It is determined by the table shown below.

But, it may be less than that shown due to: (a) the nature of the covered person's *disability;* (b) the date the covered person was first treated for the cause of his or her *disability;* and (c) the length of time the covered person has been insured by this *plan.* See "Disabilities with a Limited Maximum Payment Period" and "Pre-Existing Conditions."

For a *disability* starting before the employee reaches age 60, the *maximum payment period* will last until the Social Security Normal Retirement Age as shown in the following table:

Employee's Year of Birth	Social Security Normal Retirement Age
Before 1938	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943-1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
After 1959	67

For a *disability* starting on or after the employee reaches age 60, the *maximum payment period* will be determined according to the following table:

Age When Disability Starts	Maximum Payment Period
Age 60	5.00 years
Age 61	4.00 years
Age 62	3.50 years
Age 63	3.00 years
Age 64	2.50 years

Age 65	2.00 years
Age 66	1.75 years
Age 67	1.50 years
Age 68	1.25 years
Age 69 or older	1.00 year

But if an employee whose *disability* starts after age 60 reaches the end of the maximum payment from this table before he or she reaches the Social Security Normal Retirement Age, we will extend the *maximum payment period* until he or she reaches Social Security Normal Retirement Age.

CGP-3-LTD09-CA B383.1638

All Options

Recurring Disability

Benefits from this *plan* end if you cease to be *disabled.* But, a later *disability* may be treated as a *recurring disability,* if all of the terms listed below are met:

(a) You must return to *active work* right after your benefits end;

(b) The *disability* must recur less than six months after you were last entitled to benefits;

(c) The later *disability* must be due to the same or related cause of your earlier *disability;*

(d) This *plan* must not end during your return to *active work;*

(e) You must not become covered under any other similar group income replacement plan during the time you return to *active work;*

(f) During the time you return to *active work,* you must: (i) stay insured by this *plan;* and (ii) premium payments must be made on your behalf; and

(g) Your benefits must not have ended because you have used up the *maximum payment period.* If the later *disability* is a *recurring disability,* you will not need to complete a new *elimination period.* The *recurring disability* will be subject to all the terms of the *plan* in effect on the date the earlier *disability* began.

If all of the terms listed above are not met, the later *disability* will be treated as a new period of *disability.* You will be required to complete a new *elimination period.* The new period of *disability* will be subject to all the terms of the *plan* in effect on the date the new period of *disability* occurs.

CGP-3-LTD09-CA B383.1658

All Options

Calculation of Monthly Benefit: Your benefit is governed by the terms of the *plan* in effect on the date *disability* occurs. Any changes to this *plan* that take place: (a) while you are *disabled;* or (b) during a period of *active work* that occurs between an initial period of *disability* and a *recurring disability;* will not affect your benefit.

We calculate your *gross monthly benefit* according to the Schedule of Benefits.

From your *gross monthly benefit,* subtract the amount of any income listed in Other Income That Affects Benefits that you receive or are entitled to receive. The result is your *monthly benefit.*

CGP-3-LTD09-CA B383.1659

All Options

Redetermination: This plan redetermines *insured earnings* for each covered person on February 1st .

Each February 1st , the *plan sponsor* must report current *insured earnings* for all covered persons under the *plan.* Changes to a covered person's *insured earnings* are subject to any proof of insurability requirements of this *plan.* As of this *plan's* redetermination date, we use a covered person's *insured earnings* on record with us to: (a) set rates; (b) project benefit amounts and limits; and (c) calculate premium payable under this *plan.* However, the covered person must be *actively-at-work* on a full-time basis on that date. If you are not, we do not do this until the date you return to *active work* on a full-time basis. But, changes in earnings will not apply to a *recurring disability.*

CGP-3-LTD09-CA B383.1663

All Options

Other Income That Affects Benefits You may receive certain other income which is payable due to the same disability for which this *plan* pays benefits.

- Primary (covered person) and dependents (children and/or spouse) disability benefits under: the United States Social Security Act; the Canadian Pension Plan; the Quebec Pension Plan; or any similar plan or Act (e.g., Railroad Retirement Act).
- Temporary disability benefits under a workers compensation law.
- Amounts received under any other occupational disease law or similar act (e.g., the Longshoreman's and Harbor Workers' Act; or Maritime Doctrine of Maintenance, Wages and Cure).
- Disability benefits under the Jones Act.
- Disability benefits under any state compulsory/statutory benefit law (e.g., state disability income benefits).
- Disability benefits under any government retirement System (e.g., CalPERS).
- Disability benefits under your *employer's retirement plan* (e.g., private employer retirement plans).

- Third party liability payments by judgment, settlement or Otherwise (less attorney's fees).
- Retirement benefits under: (i) the United States Social Security Act; the Canadian Pension Plan; the Quebec Pension Plan; or any similar plan or act (e.g., Railroad Retirement Act); and (ii) your *employer's retirement plan* (e.g., private employer retirement plans).
- Amounts received by compromise or settlement of any claim for permitted offsets (less attorney's fees).

We reduce your *gross monthly benefit* by income shown above that you receive if it is paid for the same disability for which this *plan* pays benefits.

Our right to reduce your benefit by such income shall not be negated by a transfer of claim liability to a third party. Payment by such third party by law, settlement, judgment, waiver or otherwise shall not negate our right.

All Options

Other Income Not Subject to Deduction

We will not reduce your *gross monthly benefit* by any income you receive or are entitled to receive from the list below.

- Deferred compensation arrangements such as 401(k), 403(b) or 457 plans;
- Profit sharing plans;
- Thrift plans;
- Tax sheltered annuities;
- Stock ownership plans;
- Individual Retirement Accounts (IRA),
- Individual disability income plans;
- Credit disability insurance;
- Non qualified plans of deferred compensation;
- Pension plans for partners;
- Retirement plans of another employer not affiliated with this *plan;*
- Military pension and disability plans.

Lump Sum Payments of Other Income

Income listed in "Other Income That Affects Benefits" may be paid in a lump sum. In this case, we take the equivalent monthly rate stated in the award into account when we determine your *monthly benefit.* a If no monthly rate is given, we pro-rate the lump sum over the lesser of: (a) 60 months; or (b) the expected remaining number of months for which you would be entitled to benefits from this *plan,* based on the proof of loss submitted to us.

Cost of Living Freeze

You may receive a cost of living increase in income listed in "Other Income That Affects Benefits". In this case, we do not further reduce your monthly benefit by the amount of such increase.

Claim for Other Income

You must pursue a claim for other income benefits to which you may be entitled. If these benefits are denied, we may require you to appeal such denial if it is reasonable to believe that you have a valid claim to receive the benefits.

During the first 24 months in which this plan pays benefits, if you did not pursue such claim for the income benefits listed below and we have a means of reasonably estimating the amount payable, we will estimate the amount due to you and your spouse and children:

Primary (covered person) and dependents (children and/or spouse) disability benefits under: the United States Social Security Act; the Canadian Pension Plan; the Quebec Pension Plan; or any similar plan or Act (e.g., Railroad Retirement Act).

- Disability benefits under any state compulsory/statutory benefit Law (e.g., state disability income benefits).

We will take this estimated amount into account when we determine your *monthly benefit.*

If we do reduce your gross monthly benefit by an estimated amount, we will adjust your monthly benefit when we receive written proof of the amount awarded. If we underpaid you, we pay the full amount of the underpayment in a lump sum.

We offer to assist you in applying for other income benefits. Examples of the kinds of assistance we offer are: helping you fill out applications and forms; assisting you to find suitable legal counsel and providing medical and vocational data from our files to support your claims.

All Options

Adjustment of Monthly Benefit for Disability Earnings:

We adjust the *monthly benefit* for *disability earnings* as follows.

For each of the first 12 months of payments, following the date you first have *disability earnings,* add your *gross monthly benefit* and your *disability earnings.*

(a) If the sum is not more than 100% of your indexed *insured earnings,* we do not reduce your *monthly benefit.*

(b) If the sum is more than 100% of your indexed *insured earnings,* we reduce your *monthly benefit* by the amount over 100% of your indexed *insured earnings.*

For each month thereafter, we pay the greater of the amount calculated under Method 1 or Method 2.

Method 1:

(a) If your *disability earnings* are less than 20% of your indexed *insured earnings,* we do not reduce your *monthly benefit.*

(b) If your *disability earnings* are 20% or more of your indexed *insured earnings,* we reduce your *monthly benefit* by 50% of your *disability earnings.*

Method 2:

(a) Subtract your *disability earnings* from your indexed *insured earnings.*

(b) Divide the result in (a) above by your indexed *insured earnings.*

(c) Multiply the result in (b) above by your *monthly benefit.* This is the amount we pay.

If your *disability earnings* fluctuate widely from month to month, we may adjust your *monthly benefit* using an average *disability earnings* amount. The average *disability earnings* amount will be computed using your most current month's *disability earnings* and the prior two months *disability earnings.*

Maximum Allowable Disability Earnings:

This *plan* limits the amount of income you may earn and still be considered *disabled.*

If your *disability earnings* are 80% or more of your pre-disability earnings, payments from this *plan* will end for the claimed disability. Pre-disability earnings will be adjusted for inflation using the CPI-W index.

Indexing: We apply an indexing factor to your *insured earnings* on the date you have received 12 consecutive monthly payments and each anniversary thereafter. This factor increases the amount of income you may earn and still be considered *disabled.* This adjustment does not increase your *gross monthly benefit, monthly benefit,* or any other benefit under this *plan.*

To make the first adjustment, we multiply your *insured earnings* by the indexing factor for that year. To make adjustments in each later year, we multiply the amount of your last indexed *insured earnings* by the indexing factor for the current year.

The indexing factor is the *CPI-W* from the prior December.

Minimum Payment: The minimum monthly payment for *disability* under this *plan* is $100.00.

Limitations and Exclusions

Disabilities with a Limited Maximum Payment Period

We limit the *maximum payment period,* if you are *disabled* due to: (a) a *mental illness;* or (b) a substance-related disorder. However, if you have a coexistent condition, not subject to the limitations in this section, which is *disabling* in and of itself, we will not limit benefits as described below. In addition, we will not limit benefits for a substance-related disorder if the *disability* is caused by drugs administered on the advice of a doctor.

The *maximum payment period* for all periods of *disability* due to: (a) a *mental illness;* or (b) a substance-related disorder is 24 months. This is a combined maximum for all such conditions and all periods of *disability.*

No benefits will be paid for *disability* due to a *mental illness* or a substance-related disorder if you are not receiving treatment for the cause of the *disability* from a provider, or in a facility that is: (a) licensed by the state to provide treatment for such condition; and (b) accredited or approved by the Joint Commission on the Accreditation of Health Care Facilities or Medicare.

If payments under this *plan* would end due to the limits in this section, we may extend such payments, as shown below. But, you must meet all of the following conditions: (a) you must be *disabled* due to a condition named above; (b) you must be an inpatient in a qualified institution because of your *disability;* and (c) you must have been treated as an inpatient for at least 14 days in a row. In such case, we extend payments until the earliest of: (i) 90 days from the date of your discharge; (ii) the end of this *plan's maximum payment period;* or (iii) the date your *disability* ends.

The term "qualified institution" means a legally operated hospital or other public or private facility licensed to provide inpatient medical care and treatment for the cause of your *disability.*

All Options

Pre-Existing Conditions

You are not covered for a *disability* caused or substantially contributed to by a pre-existing condition or medical or surgical treatment of a pre-existing condition.

You have a pre-existing condition if:

(a) You received medical treatment, care or services for a diagnosed condition or took prescribed medication for a diagnosed condition in the three months immediately prior to the effective date of your insurance under this *plan;* or

You suffered from a physical, or mental condition, whether diagnosed or undiagnosed, which was misrepresented or not disclosed in your Application (i) for which you received a *doctor's* advice or treatment within three months before the effective date of your insurance under this *plan,* or (ii) which caused symptoms within three months before the effective date of your insurance under this *plan* for which a prudent person would usually seek medical advice or treatment; and

(b) the *disability* caused or substantially contributed to by the condition begins in the first 12 months after the effective date of your insurance under this *plan.*

CGP-3-LTD09-CA B383.1711

All Options

Prior Coverage Credit:

If this *plan* replaces a similar income replacement plan the *plan sponsor* had with another insurer, the pre-existing condition provision may not apply to you. This *plan* must start right after the old plan ends.

The pre-existing condition provision will be waived for any covered person who: (a) is *actively working* on the effective date of this *plan;* and (b) fulfilled the requirements of any pre- existing condition provision of the old plan.

If you: (a) were covered under the old plan when it ended; (b) enroll for insurance under this *plan* on or before this *plan's* effective date; and (c)are *actively working* on the effective date of this *plan;* but (d) have not fulfilled the requirements of any pre-existing condition provision of the old plan; we credit any time used to meet the old plan's pre-existing condition provision toward meeting this *plan's* pre-existing condition provision.

But, we limit your *maximum monthly benefit* under this *plan* if: (a) it is more than the maximum monthly benefit for which you were insured under the old plan; (b) you become *disabled* due to a pre-existing condition; and (c) this *plan* pays benefits for such *disability* because we credit time as explained above. In this case, we limit the *maximum monthly benefit* to the amount you would have been entitled to under the old plan.

We deduct all payments made by the old plan under an extension provision.

CGP-3-LTD09-CA B383.1684

All Options

Exclusions

This *plan* does not pay benefits for *disability* caused by:

(a) declared or undeclared war, act of war, or armed aggression;

(b) service in the armed forces, National Guard, or military reserves of any state or country;

(c) you taking part in a riot or civil disorder;

(d) your commission of, or attempt to commit a felony, for which you have been convicted;

(e) you being engaged in an illegal occupation; or

(f) intentional self-inflicted injuries.

We do not pay any benefits for any period of *disability:*

(1) during which you are confined to a facility as a result of your conviction of a crime; or

(2) which starts before you are insured by this *plan.*

Services

Social Security Assistance: This *plan* requires all *disabled* covered persons to Pursue a claims for Social Security benefits. (See the "Claims for Other Income" section of this *plan.)* We may offer to assist you in applying for them. Receiving Social Security benefits will protect your earnings record for retirement and enable you to qualify for Medicare coverage after 24 months.

Services we can provide include:

(a) Help in completing your application for such benefits, and any related forms;

(b) Assistance finding suitable legal counsel; and

(c) Copies of medical and vocational data needed to file your claim.

We may also provide these and other services if your benefits are under review for possible termination by the Social Security Administration.

You must pursue a claims for all income benefits for which you may be eligible, whether or not you use our help. Using our help does not cancel your duties shown in the "Claim for Other Income" section of this *plan.*

Rehabilitation and Case Management: We will review your *disability* to see if certain services are likely to help him or her return to work in your *usual occupation.* If needed, we may ask for more medical or vocational information.

When our review is complete, we may offer you a *rehabilitation program.*

The *rehabilitation program* will start when a written *rehabilitation agreement* is signed by: (1) you; (2) us; and (3) your *employer,* if needed. The program may include, but is not limited to:

(a) vocational evaluation of your work potential;

(b) coordination and transition planning with an employer for your return to work;

(c) consulting with your *doctor* on your return to work and need for accommodations;

(d) training in job seeking skills and resume preparation;

(e) retraining; and

(f) assistance with family care expenses you incur in order to participate in a *rehabilitation program.* (See the "Dependent Care Expenses" section of this *plan.)*

The extent of our role in this program will be determined by the written agreement.

If the you accept the *rehabilitation agreement,* we will pay an enhanced benefit. The enhanced benefit will be 110% of the *monthly benefit* that would otherwise be paid. This enhanced benefit will be payable as of the first *monthly benefit* after the *rehabilitation program* starts.

We stop paying the enhanced benefit on the earliest of:

(a) The date your benefits from this *plan* end;

(b) The date you violate the terms of the *rehabilitation agreement;*

(c) The date you end the *rehabilitation program;* and

(d) The date the *rehabilitation agreement* ends.

Dependent Care Expenses: While you are participating in a *rehabilitation program,* we will pay a dependent care expense benefit, when all of the following conditions are met:

(a) you incur expense to provide care for a qualified dependent;

(b) the care is provided by a licensed provider other than a family member.

A qualified dependent is: (a) dependent upon the covered person for main support and maintenance; and (b) under the age of fourteen and your: (i) biological child; (ii) lawfully adopted child; (iii) stepchild; or (iv) any other child who is living with you in a regular parent-child relationship; or (c) a family member age 14 or over who is physically or mentally incapable of caring for him or herself.

The dependent care expense benefit will be the lesser of: (a) $350 per month per qualified dependent; not to exceed $1,000 per month for all qualified dependents combined; and (b) the actual monthly day care expense incurred by you.

We will stop paying the dependent care expense benefit on the earlier of the date you are no longer: (a) incurring dependent care expenses for a qualified dependent; (b) participating in a *rehabilitation program;* or (c) entitled to receive a *monthly benefit* from this *plan.*

All Options

Worksite Modification Benefit: In order to accommodate your *disability,* an employer may incur a cost to modify his or her worksite. We may reimburse the employer, up to $2,500 for the cost of the worksite modification. We make this payment if we agree that the modification will enable the covered person to: (a) return to work; or (b) remain at work.

CGP-3-LTD09-CA B383.1687

All Options

The Survivor Benefit We may pay a survivor benefit if you die after you: (a) had been *disabled* for at least six months in a row; and (b) were entitled to receive at least one full *monthly benefit.* When we receive proof of your death, we pay your eligible survivor a lump sum benefit.

We pay a benefit equal to 3 times the amount of your last *monthly benefit* after it is reduced by *disability earnings.* but, we first apply such benefit to reduce any overpayment you may owe us.

If you have no eligible survivor, no survivor benefit is paid.

Your eligible survivor is your spouse, if living.

If your spouse is not living, your eligible survivor is your: (a) unmarried child under age 20 ; and (b) unmarried child under age 26 who is enrolled as a full-time student at an accredited school. If there is more than one such child when you die, this benefit will be paid to each child in equal shares.

Accelerated Survivor Benefit If you have a terminal illness, we may accelerate payment of this *plans'* survivor benefit.

For purposes of the accelerated survivor benefit, a terminal illness means a medical condition that is expected to result in your death within 6 months.

To receive an accelerated survivor benefit, you must: (a) be entitled to receive a *monthly benefit* from this *plan;* (b) request this benefit in writing; and (c) provide written proof of terminal illness from a *doctor.* However, we will not pay an accelerated survivor benefit if there are less than 6 months remaining in the maximum benefit period.

If you elect to receive an accelerated survivor benefit, no survivor benefit is payable upon your death.

CGP-3-LTD09-CA B383.1692

All Options

Income Recovery Benefit

This *plan* may pay an Income Recovery Benefit, if *monthly benefits* cease because you are no longer *disabled.*

To be eligible for the Income Recovery Benefit, you must be:

(a) able to perform the substantial and material acts of your *own occupation; and*

(b) working in your *own occupation* the same number of hours as you did prior to *disability;* and

(c) unable to earn this *plan's* maximum allowable *disability earnings,* due to the *sickness* or *injury* which caused the prior *disability.*

We pay this benefit monthly, in arrears. We determine the amount we pay in two steps. In step one, we compute the following: (a) your gross monthly benefit as of the last month you were disabled under the terms of this *plan;* less (b) any other income this *plan* integrates with that you are entitled to receive. In step two we make a current earnings adjustment. We add: (a) your *gross monthly benefit* as of the last month you were disabled under the terms of this *plan;* and (b) your current *disability earnings.* If such sum exceeds 100% of your insured earnings, we pay the amount in step one less the excess over 100%. If such sum does not exceed 100%, we pay the amount in step one.

We stop paying this benefit on the earliest of:

(a) the date you are able to earn this *plan's* maximum allowable *disability earnings;*

(b) the date you become disabled;

(c) the date you stop working;

(d) the date 12 consecutive months after the first Income Recovery Benefit is paid; or

(e) the end of the *maximum payment period.*

We will not pay more than 12 monthly Income Recovery Benefit payments following any one period of *disability,* including any *recurrent disability.*

CGP-3-LTD07-9.5 B383.1742

All Options

Claim Provisions

Authority

We have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine your eligibility for benefits under the *plan.*

We will:

(1) obtain only such information that is necessary to evaluate a claim for benefits. This information will be obtained as set forth herein with respect to notice and proofs of loss.

(2) consider and interpret the terms of this *plan* and all information obtained by us and submitted that relates to a claim for benefits and make a determination based on that information and in accordance with the terms of this *plan* and applicable California state law.

(3) if a claim is approved, review the determination as often as is reasonably necessary to determine continued eligibility for benefits.

(4) if a claim is denied, provide the claimant within a reasonable period of time a written notification of an adverse determination. Such notification will include the specific reason(s) for the adverse determination.

If a claim is wholly or partially denied, the claimant may appeal the decision. Guardian will conduct a full and fair review of an appeal. The review will take into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. If a claim is not appealed, then the decision will be Guardian's final decision.

Notice You must send us written notice of an injury or sickness for which a claim is being made within 20 days of the date the injury occurs or the sickness starts, or as soon thereafter as is reasonably possible. This notice should include your name and plan number.

For details, you can call Guardian at 1-800-538-4583.

Claims Forms We, upon receipt of a written notice of claim, will furnish to you such forms as are usually furnished by us for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice, you shall be deemed to have complied with the requirements of the *plan* as to proof of loss upon submitting, within the time fixed in the *plan* for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which the claim is made.

Proof of Loss Written proof of loss must be furnished to us, in case of claim for loss for which the *plan* provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which we are liable, and in case of claim for any other loss, within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of your legal capacity, later than one year from the time proof is otherwise required.

Proof of loss and other claim data should be submitted to:

The Guardian Life Insurance Company of America
Group Long Term Disability Claims Department
P.O. Box 26025
Lehigh Valley, PA 18002-6025.

Authorization Required You must provide us with written, unaltered authorizations to obtain medical, financial, vocational, occupational, and governmental information required to determine our liability under this *plan.* You must provide us with such authorizations as often as we may require, in order that they remain current. Failure to provide such authorizations may delay, suspend or terminate your benefits.

Examinations We, at our own expense, shall have the right and opportunity to examine you when and as often as it may reasonably require during the pendency of a claim hereunder.

Ongoing Proof of Loss To continue to receive payments from this plan, you must give us current proof of loss as often as we may reasonably require. Ongoing proof of loss must be provided to us within 90 days of the date we request it. Failure to furnish such proof within the time period required shall not invalidate or reduce any claim provided such items are sent as soon as reasonably possible.

Payment of Benefits We pay benefits to you, if you are legally competent. If you are not, we pay benefits to your legal representative. Benefits are paid in US dollars.

We pay benefits once each month at the end of the period for which they are payable.

No benefits are payable for this plan's elimination period.

Benefits to which you are entitled may remain unpaid at your death. If any benefit is payable to your estate, or to a minor who is not otherwise competent to give a valid release, we pay the benefit, up to an amount not exceeding $1,000, to any relative by blood or connection by marriage who is considered by us to be entitled to the benefit. Any payment made in good faith pursuant to this provision shall fully discharge Guardian to the extent of such payment.

Partial Month Payment You may be disabled for only part of a month. In this case, we compute your payment as 1/30th of the benefit to which you would be entitled for the full month times the number of days you are disabled. Payment will not be made for more than 30 days in any month.

Overpayment Recovery If we overpaid you, you must repay us in full. We have the right to reduce your payment or apply any benefits payable, including the minimum payment, toward recovery of the overpayment.

Legal Actions If we overpaid you, you must repay us in full. We have the right to reduce your payment or apply any benefits payable, including the minimum payment, toward recovery of the overpayment. No action at law or in equity shall be brought to recover on the plan prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the plan. No such action shall be brought after the expiration of three years after time written proof of loss is required to be furnished.

Definitions

Active Work, Actively-At-Work or Actively Working You are able to perform and are performing the regular duties of your work for your *employer,* on a full-time basis at: (a) one of your *employer's* usual places of business; (b) some place where your *employer's* business requires you to travel; or (c) any other place you and your *employer* have agreed on for your work.

CPI-W That part of the United States Department of Labor Consumer Price Index that measures the relative value of the cost of a typical urban wage earner's purchase of certain goods and services. If the Department of Labor stops publishing the *CPI-W,* we have the right to use some other similar standard.

Disability or Disabled These terms, when used alone, mean: (a) total disability or totally disabled; or (b) partial or residual disability.

Total Disability or Totally Disabled means that as a result of *sickness* or *injury,* you are not able to perform with reasonable continuity the substantial and material acts necessary to pursue your usual occupation and you are not working in your usual occupation.

Substantial and material acts means the important tasks, functions and operations generally required by employers from those engaged in your usual occupation that cannot be reasonably omitted or modified.

In determining what substantial and material acts are necessary to pursue your usual occupation, we will first look at the specific duties required by the *employer* or job. If you are unable to perform one or more of these duties with reasonable continuity, we will then determine whether those duties are customarily required of other persons engaged in your usual occupation. If any specific, material duties required of you by the *employer* or job differ from the material duties customarily required of other persons engaged in your usual occupation, then we will not consider those duties in determining what substantial and material acts are necessary to pursue your usual occupation.

Usual occupation may be interpreted to mean the employment, business, trade or profession that involves the substantial and material acts of the occupation you were regularly performing for the *employer* when the disability began. Usual occupation is not necessarily limited to the specific job you performed for the *employer.*

Partial or Residual Disabilitymeans you are not *totally disabled* and that while actually working in an occupation, as a result of *sickness* or *injury,* you are unable to earn 80% or more of your pre- disability earnings. Pre-disability earnings will be adjusted for inflation using the CPI-W index.

All Options

Disability Earnings The monthly income you earn from working while *disabled.* It includes salaries, wages, commissions, bonuses and any other compensation earned or accrued while working including pension, profit sharing contributions, sick pay, paid time off, holiday and vacation pay. When you have an ownership interest in the business, *disability earnings* also includes business profits, attributable to you, whether received or not. It includes any income you earn while *disabled* and return to your *employer,* partnership, or any other similar business arrangement to cover any business or overhead expenses. If you had secondary employment prior to *disability, disability earnings* will only include earnings from the secondary employment if that employment began after the beginning of your disability.

Doctor Any medical practitioner we are required by law to recognize. He or she must: (a) be properly licensed or certified by the laws of the state where he or she practices; and (b) provide services that are within the lawful scope of his or her practice.

Elimination Period The period of time you must be *disabled,* due to a covered *disability,* before this *plan's* benefits are payable.

Any days during which you return to work earning more than **80%** of your *insured earnings* will not count toward the *elimination period.* If you become eligible under any other similar group income replacement plan while you are working during the elimination period, you will not be entitled to benefits from this *plan.*

We do not require you to complete an elimination period if: (a) you were covered under a similar income replacement plan the plan sponsor had with another insurer on the day before this plan starts; (b) your disability would have been a recurring disability under the prior plan had it remained in effect.

Employer The business entity that employs you and is: (a) the plan sponsor; or (b) associated with the plan sponsor.

Gross Monthly Benefit This plan's monthly benefit before it is reduced by other income and earnings.

Injury Physical harm or damage to your body that occurs while you are insured by this plan.

All Options

Insured Earnings Only your earnings from the *employer* will be included as *insured earnings.*

We calculate benefit amounts and limits based on the amount of your *insured earnings* as of the Redetermination date immediately prior to the start of your *disability.* See the "Redetermination" section of this *plan.*

For Partners and S Corporation Shareholders:

Insured earnings means the sum of the amounts listed below, divided by 12.

(a) Your compensation as an employee or S Corporation shareholder, as reported on your Federal Income Tax Return, Form 1040, for the prior calendar year, less the gross total of unadjusted employee business expenses as included on the corresponding Schedule A-Itemized Deductions;

(b) Your non-passive income (loss) from trade or business as reported on Schedule E-Part II of your Federal Income Tax Return, Form 1040, for the prior calendar year, less any expenses incurred and reported elsewhere on your Return; and

(c) Your contributions during the prior calendar year, deposited into a: (a) cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section: 401(k); 403(b); 457; or similar plan; and (b) elective employee pre-tax deferrals to a Section 125 plan or flexible spending account.

You may not have been a partner or S Corporation shareholder for the entire previous calendar year. In this case, your earnings are based on the monthly average of the sum of the listed amounts, averaged for the full number of months that you were a partner or an S Corporation shareholder during such calendar year.

For Sole Proprietors:

Insured earnings means: (a) the average monthly net profit as determined from Schedule C - Part II of your Federal Income Tax Returns, Form 1040, for the prior calendar year; plus (b) your average monthly contribution during the prior calendar year deposited into a: (i) cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section: 401(k); 403(b); 457; or similar plan; and (ii) a Section 125 plan or flexible spending account. Monthly net profit is calculated as gross income less total expenses. You may not have been a sole proprietor for the previous calendar year. In this case, we calculate average monthly net profit and average monthly contributions using the full number of months that you were a sole proprietor during such calendar year.

For Covered Persons Who Are Compensated on Less Than a 12 Month Basis:

Insured earnings means your average rate of monthly earnings determined from your annual contract salary. Insured earnings also includes your contributions deposited into a: (a) cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section: 401(k); 403(b); 457; or similar plan; and (b) elective employee pre-tax deferrals to a Section 125 plan or flexible spending account. Insured earnings does not include bonuses, commissions, overtime pay, expense accounts, stock options and any other extra compensation. We do not include pay for hours worked or billed over 40 per week. Earnings based on excluded income and employer contributions deposited into such 401(k); 403(b); 457; or similar plan are excluded.

For Covered Persons Whose Income Is Reported on a IRS Form 1099:

Insured earnings means your average rate of monthly earnings as figured from the 1099 form received from the employer for the prior calendar year, calculated as (a) minus (b), divided by 12 or the number of months you worked for the employer during such calendar year, if less than 12.

(a) your earned income as reported on the 1099 form.

(b) business expenses, as reported on Schedule C - Part II of your Federal Income Tax Return, Form 1040.

Insured earnings also includes your contributions deposited into a: (a) cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section: 401(k); 403(b); 457; or similar plan; and (b) elective employee pre-tax deferrals to a Section 125 plan or flexible spending account.

Earnings based on excluded income and employer contributions deposited into such 401(k); 403(b); 457; or similar plan are excluded.

For All Other Covered Persons:

W-2, Preceding Calendar Year:

Insured earnings means the covered person's rate of monthly earnings as figured from the W-2 forms received from the employer for the prior calendar year. We include as earnings: (a) taxable earned income, including: (i) bonuses; (ii) commissions; and (iii) overtime pay; (b) elective employee pre-tax deferrals to a Section 125 plan or flexible spending account; and (c) contributions to a cash or deferred compensation plan, or a salary reduction plan, qualified under IRC Section 401(k), 403(b) or 457, as reported on the covered person's W-2 form. We do not include as earnings: (1) expense accounts and other extra compensation; (2) stock options exercised; or (3) employer contributions to a cash or deferred compensation plan or salary reduction plan. If the covered person was not employed by the employer for the entire prior calendar year, insured earnings are based on the monthly average of the sum of the listed amounts, averaged for the full number of months that he or she was employed by the employer, during such calendar year.

All Options

Maximum Payment Period The longest time that benefits are paid by this *plan.*

Mental Illness Means any mental disorder, regardless of cause, listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM) currently in use by the American Psychiatric Association (APA). If the APA stops publishing the DSM, we have the right to use some other similar standard. A *mental illness* may be: (a) caused by; (b) contributed to by; or (c) result in; physical, biological or chemical factors or symptoms. For purposes of this *plan, mental illness* does not include: (a) irreversible dementia caused by Alzheimer's disease, stroke, trauma or viral infection; or (b) any other condition not typically treated by a psychiatrist, clinical psychologist or other qualified mental health practitioner with psychotherapy or psychotropic drugs.

Monthly Benefit This *plan's gross monthly benefit* reduced by other income. If you are working while *disabled,* your *monthly benefit* will be further reduced based on the amount of your *disability earnings.*

Own Occupation or Usual Occupation means the occupation: (a) you are routinely performing immediately prior to disability; (b) which is your primary source of income prior to disability; and (c) for which you are insured under this plan. Occupation includes any employment, business, trade or profession that involves the substantial and material acts of the occupation you were regularly performing for the employer when the disability began. Own occupation or usual occupation is not necessarily limited to the specific job you performed for the employer.

All Options

Plan Sponsor The *employer,* association, union, trustee, or other group to which this *plan* is issued.

Recurring Disability A later *disability* that: (a) is related to an earlier *disability* for which this *plan* paid benefits; and (b) meets the conditions described in "Recurring Disability."

Rehabilitation Agreement A formal agreement between: (a) you; (b) us; and (c) your *employer,* if needed. It outlines the *rehabilitation program* in which you agree to take part.

Rehabilitation Program A program of work or job-related training for you that we approve in writing. Its aim is to restore your wage earning abilities.

Retirement Plan A defined benefit or defined contribution plan funded wholly or in part by the *employer's* deposits for your benefit. The term does not include: (a) profit sharing plans; (b) thrift plans; (c) non-qualified deferred compensation plans; (d) individual retirement accounts; (e) tax sheltered annuities; (f) 401(k), 403(b), 457 or similar plans; or (g) stock ownership plans.

Retirement Plan **"retirement benefits"** are lump sum or periodic payments at normal or early retirement. Some *retirement plans* make payments for disability (as defined by those plans) that start before normal retirement age. When such payments reduce the amount that would have been paid at normal retirement age, they are *retirement benefits.* When such payments do not reduce the normal retirement amount, they are **"disability benefits."**

Sickness An illness or disease. Pregnancy is treated as a *sickness* under this *plan.*

Spouse This term means your lawful spouse or registered domestic partner.

Substance-Related Disorder Means alcoholism or drug addiction listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM) currently in use by the American Psychiatric Association (APA). If the APA stops publishing the DSM, we have the right to use some other similar standard. A *substance-related disorder* may be: (a) caused by; (b) contributed to by; or (c) result in; physical, biological or chemical factors or symptoms. For purposes of this *plan,* these disorders do not include: (a) irreversible dementia caused by Alzheimer's disease, stroke, trauma or viral infection; or (b) any other condition not typically treated by a psychiatrist, clinical psychologist or other qualified mental health practitioner with psychotherapy or psychotropic drugs.

We, Us, and Guardian The Guardian Life Insurance Company of America.

Option A

ELIGIBILITY FOR DENTAL COVERAGE

B489.0002

Option A

Employee Coverage

Eligible Employees

To be eligible for *employee* coverage you must be an active *full-time employee.* And you must belong to a class of *employees* covered by this *plan.*

Other Conditions

If you must pay all or part of the cost of *employee* coverage, we won't insure you until you enroll and agree to make the required payments. If you do this: (a) more than 31 days after you first become eligible; or (b) after you previously had coverage which ended because you failed to make a required payment, we consider you to be a late entrant.

If you initially waived dental coverage under this *plan* because you were covered under another group *plan,* and you now elect to enroll in the dental coverage under this *plan,* the Penalty for Late Entrants provision will not apply to you with regard to dental coverage provided your coverage under the other *plan* ends due to one of the following events: (a) termination of your spouse's employment; (b) loss of eligibility under your spouse's *plan;* (c) divorce; (d) death of your spouse; or (e) termination of the other *plan.*

But you must enroll in the dental coverage under this *plan* within 30 days of the date that any of the events described above occur.

CGP-3-EC-90-1.0 B489.0122

Option A

Dental Plan Election Procedures

Since Managed DentalGuard is offered to you as an alternative to this dental coverage, you may change your election, and enroll in Managed DentalGuard as follows.

If you drop your coverage under this *plan,* at any time other than during an open enrollment period, you may not enroll in Managed DentalGuard until the open enrollment period which starts at least 12 months after the date coverage is dropped.

If you remain covered under this plan, you may change your election, and enroll in Managed DentalGuard during an open enrollment period. Your coverage under this *plan* ends on the date coverage under Managed DentalGuard begins.

An "open enrollment period" is a 30 day period occurring once every 12 months after this plan's effective date, or at time intervals agreed upon by the *employer* and us.

If you change your election, your covered dependents will automatically be switched to Managed DentalGuard at the same time as you.

CGP-3-EC-90-1.0 B489.0137

Option A

When Your Coverage Starts

Employee benefits are scheduled to start on your effective date.

But you must be actively at work on a *full-time* basis on the scheduled effective date. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are not actively at work on the date your insurance is scheduled to start, we will postpone your coverage until the date you return to active *full-time* work.

Sometimes, your effective date is not a regularly scheduled work day. But coverage will still start on that date if you were actively at work on a *full-time* basis on your last regularly scheduled work day.

CGP-3-EC-90-2.0 B489.0070

Option A

When Your Coverage Ends

Your coverage ends on the last day of the month in which your active *full-time* service ends for any reason, other than disability. Such reasons include retirement, layoff, leave of absence and the end of employment.

Your coverage ends on the date you die.

It also ends on the date you stop being a member of a class of *employees* eligible for insurance under this *plan,* or when this *plan* ends for all *employees.* And it ends when this *plan* is changed so that benefits for the class of *employees* to which you belong ends.

If you are required to pay all or part of the cost of this coverage and you fail to do so, your coverage ends. It ends on the last day of the period for which you made the required payments, unless coverage ends earlier for other reasons.

Read this booklet carefully if your coverage ends. You may have the right to continue certain group benefits for a limited time.

CGP-3-EC-90-3.0 B489.0075

Option A

Your Right To Continue Group Coverage During A Family Leave Of Absence

Coverage During a Temporary Leave

If your active full-time service ends because you are disabled by pregnancy, childbirth or a related medical condition you may continue your coverage for up to four months during any twelve consecutive months.

Your employer may recover from you any premium paid if: 1) you fails to return from leave after four months; and 2) your failure to return is for a reason other that one of the following: (a) your taking leave under the Moore-Brown-Roberti Family Rights Act; (b) the continuation, recurrence, or onset of a health condition that entitles you to leave is beyond your control; or (c) if your employer is a state agency, the collective bargaining agreement will govern.

CGP-3-EC-90-3.0 B489.0628

Option A

Dependent Coverage

B200.0271

Option A

Eligible Dependents For Dependent Dental Benefits

Your *eligible dependents* are: (a) your legal spouse; (b) your dependent children who are under age 26.

CGP-3-DEP-90-2.0 B489.0460

Option A

Adopted Children And Step-Children

Your "dependent children" include your legally adopted children and, your step-children.

We treat a child as legally adopted from the time the child is placed in your physical custody for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. We cover your adopted child from the moment of his or her placement if you are already covered for dependent child coverage when the child is placed for adoption. If you do not have dependent coverage when the child is placed for adoption, we cover the child for the first 31 days from the moment of his or her placement. To continue the child's coverage past the 31 days, you must enroll the child and agree to make any required premium payments within 31 days of the date of placement. If you fail to do this, the child's coverage will end at the end of the 31 days. The child won't be covered by this plan again until you enroll the child. Then the child will be covered as of the date you sign the enrollment form and will be a late entrant and subject to any applicable late entrant penalties.

If this plan has pre-existing restrictions, they will not apply to a minor child adopted by you after this plan starts.

Dependents Not Eligible

We exclude any dependent who is insured by this plan as an employee. And we exclude any dependent who is on active duty in any armed force.

CGP-3-DEP-90-3.1 B489.0499

Option A

Handicapped Children

You may have an unmarried child with a mental or physical handicap, or developmental disability, who can't support himself or herself. Subject to all of the terms of this coverage and the *plan,* such a child may stay eligible for dependent benefits past this coverage's age limit.

The child will stay eligible as long as he or she stays unmarried and unable to support himself or herself, if: (a) his or her conditions started before he or she reached this coverage's age limit; (b) he or she became insured by this coverage before he or she reached the age limit, and stayed continuously insured until he or she reached such limit; and (c) he or she depends on you for most of his or her support and maintenance.

But, for the child to stay eligible, you must send us written proof that the child is handicapped and depends on you for most of his or her support and maintenance. You have 31 days from the date the child reaches the age limit to do this. We can ask for periodic proof that the child's condition continues. But, after two years, we can't ask for this proof more than once a year.

The child's coverage ends when yours does.

CGP-3-DEP-90-4.0 B449.0042

Option A

Waiver Of Dental Late Entrants Penalty

If you initially waived dental coverage for your spouse or eligible dependent children under this plan because they were covered under another group plan, and you now elect to enroll them in the dental coverage under this plan, the Penalty for Late Entrants provision will not apply to them with regard to dental coverage provided their coverage under the other plan ends due to one of the following events: (a) termination of your spouse's employment; (b) loss of eligibility under your spouse's plan; (c) divorce; (d) death of your spouse; or (e) termination of the other plan.

But you must enroll your spouse or eligible dependent children in the dental coverage under this plan within 30 days of the date that any of the events described above occur.

In addition, the Penalty for Late Entrants provision for dental coverage will not apply to your spouse or eligible dependent children if: (a) you are under legal obligation to provide dental coverage due to a court-order; and (b) you enroll them in the dental coverage under this plan within 30 days of the issuance of the court-order.

CGP-3-DEP-90-5.0 B200.0749

Option A

When Dependent Coverage Starts

In order for your dependent coverage to begin you must already be insured for employee coverage or enroll for employee and dependent coverage at the same time. Subject to the "Exception" stated below and to all of the terms of this *plan,* the date your dependent coverage starts depends on when you elect to enroll your *initial dependents* and agree to make any required payments.

If you do this on or before your *eligibility date,* the dependent's coverage is scheduled to start on the later of the first of the month which coincides with or next follows your *eligibility date* and the date you become insured for employee coverage.

If you do this within the *enrollment period,* the coverage is scheduled to start on the later of the first of the month which coincides with or next follows the date you sign the enrollment form; and the date you become insured for employee coverage.

If you do this after the *enrollment period* ends, each of your *initial dependents* is a late entrant and is subject to any applicable late entrant penalties. The dependent's coverage is scheduled to start on the first of the month which coincides with or next follows the date you sign the enrollment form.

Once you have dependent coverage for your *initial dependents,* you must notify us when you acquire any new dependents and agree to make any additional payments required for their coverage.

If you do this within 31 days of the date the *newly acquired dependent* becomes eligible, the dependent's coverage will start on the date the dependent first becomes eligible. If you fail to notify us on time, the *newly acquired dependent,* when enrolled, is a late entrant and is subject to any applicable late entrant penalties. The late entrant's coverage is scheduled to start on the date you sign the enrollment form.

CGP-3-DEP-90-6.0 B489.0055

Option A

Exception

If a dependent, other than a newborn child, is confined to a *hospital* or other health care facility; or is home-confined; or is unable to carry out the normal activities of someone of like age and sex on the date his dependent benefits would otherwise start, we will postpone the effective date of such benefits until the day after his discharge from such facility; until home confinement ends; or until he resumes the normal activities of someone of like age and sex.

CGP-3-DEP-90-7.0 B200.0692

Option A

Newborn Children We cover your newborn child from the moment of birth if you are already covered for dependent child coverage when the child is born. If you do not have dependent coverage when the child is born, we cover the child for the first 31 days from the moment of his or her birth. To continue the child's coverage past the 31 days, you must enroll the child and agree to make any required premium payments within 31 days of the date the child is born. If you fail to do this, the child's coverage will end at the end of the 31 days. The child won't be covered by this plan again until you enroll the child. Then the child will be covered as of the date you sign the enrollment form and will be a late entrant and subject to any applicable late entrant penalties.

CGP-3-DEP-90-8.0 B489.0232

Option A

When Dependent Coverage Ends Dependent coverage ends for all of your dependents when your coverage ends. But if you die while insured, we'll automatically continue dependent benefits for those of your dependents who were insured when you died. We'll do this for six months at no cost, provided: (a) the group plan remains in force; (b) the dependents remain *eligible dependents;* and (c) in the case of a spouse, the spouse does not remarry.

If a surviving dependent elects to continue his or her dependent benefits under this *plan's* "Federal Continuation Rights" provision, or under any other continuation provision of this *plan,* if any, this free continuation period will be provided as the first six months of such continuation. Premiums required to be paid by, or on behalf of a surviving dependent will be waived for the first six months of continuation, subject to restrictions (a), (b) and (c) above. After the first six months of continuation, the remainder of the continuation period, if any, will be subject to the premium requirements, and all of the terms of the "Federal Continuation Rights" or other continuation provisions.

Dependent coverage also ends for all of your dependents when you stop being a member of a class of *employees* eligible for such coverage. And it ends when this *plan* ends, or when dependent coverage is dropped from this *plan* for all *employees* or for an *employee's* class.

If you are required to pay all or part of the cost of dependent coverage, and you fail to do so, your dependent coverage ends. It ends on the last day of the period for which you made the required payments, unless coverage ends earlier for other reasons.

An individual dependent's coverage ends when he or she stops being an *eligible dependent.* This happens to a child at 12:01 a.m. on the date the child attains this coverage's age limit. It happens to a spouse when a marriage ends in legal divorce or annulment.

Read this *plan* carefully if dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time.

CGP-3-DEP-90-9.0 B489.0468

Option A

CERTIFICATE AMENDMENT

Effective June 1, 2008, this rider amends the dependent coverage provisions as follows:

Your domestic partner will be eligible for coverage under this plan subject to all of the terms of this plan and the limitations below. "Domestic partner" means an adult who has chosen to share his or her life with you in an intimate and committed relationship of mutual caring.

To qualify for such coverage, you and your domestic partner must be registered domestic partners.

As used here:

"Registered domestic partners" means an employee and his or her domestic partner who: (a) have filed a Declaration of Domestic Partnership with the California Secretary of State; (b) were registered as a domestic partner in the registry for those partnerships; and (c) were issued a copy of the registered form and a Certificate of Registered Domestic Partnership.

Your registered domestic partner will be eligible for dental coverage under this plan.

A registered domestic partner's dependent children will be eligible for coverage under this plan on the same basis as if the children were your dependent children.

Coverage for a registered domestic partner and his or her dependent children ends when the domestic partnership is dissolved as provided under California law.

A registered domestic partner will have all of the rights of a spouse under this plan except that the continuation of dental coverage as explained under the "Federal Continuation Rights" section is available to a registered domestic partner and his or her children only if you are also eligible for and elect continuation.

This rider is a part of this plan. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this plan.

The Guardian Life Insurance Company of America

Stuart J Shaw

Vice President, Risk Mgt. & Chief Actuary

CGP-3-A-DMST-CA-05 B489.0222

Option A

DENTAL HIGHLIGHTS

This page provides a quick guide to some of the Dental Expense Insurance *plan* features which people most often want to know about. But it's not a complete description of your Dental Expense Insurance *plan.* Read the following pages carefully for a complete explanation of what we pay, limit and exclude.

- **PPO Benefit Year Cash Deductible for Non-Orthodontic Services**

  For Group I Services . . . . . None
  For Group II and III Services $50.00
  for each covered person

- **Non-PPO Benefit Year Cash Deductible for Non-Orthodontic Services**

  For Group I Services . . . . . None
  For Group II and III Services $50.00
  for each covered person

CGP-3-DENT-HL-90 B497.0070

Option A

- **Payment Rates for Services Furnished by a Preferred Provider:**

  For Group I Services 100%
  For Group II Services 80%
  For Group III Services 50%

- **Payment Rates for Services Not Furnished by a Preferred Provider:**

  For Group I Services 80%
  For Group II Services 80%
  For Group III Services 50%

CGP-3-DENT-HL-90 B497.0088

Option A

- **Benefit Year Payment Limit for Non-Orthodontic Services**

  For Group I, II and III Services . . . . . Up to $2,000.00

Note: A covered person may be eligible for a rollover of a portion of his or her unused Benefit Year Payment Limit for Non-Orthodontic Services. See "Rollover of Benefit Year Payment Limit for Non-Orthodontic Services" for details.

CGP-3-DENT-HL-90 B497.1431

Option A

Group Enrollment Period

A group enrollment period is held each year. The group enrollment period is a time period agreed to by your employer and us. During this period, you may elect to enroll in dental insurance under this *plan.* Coverage starts on the first day of the month that next follows the date of enrollment. You and your *eligible dependents* are not subject to late entrant penalties if you enroll during the group enrollment period.

CGP-3-DENT-HLTS B497.2411

Option A

DENTAL EXPENSE INSURANCE

This insurance will pay many of a *covered person's* dental expenses. *We* pay benefits for covered charges incurred by a *covered person.* What *we* pay and terms for payment are explained below.

CGP-3-DG2000 B498.0007

Option A

DentalGuard Preferred - This Plan's Dental Preferred Provider Organization

This *plan* is designed to provide high quality dental care while controlling the cost of such care. To do this, the *plan* encourages a *covered person* to seek dental care from *dentists* and dental care facilities that are under contract with *Guardian's dental preferred provider organization (PPO),* which is called DentalGuard Preferred.

The dental PPO is made up of *preferred providers* in a covered person's geographic area. Use of the dental PPO is voluntary. A *covered person* may receive dental treatment from any dental provider he or she chooses. And he or she is free to change providers anytime.

This *plan* usually pays a higher level of benefits for covered treatment furnished by a *preferred provider.* Conversely, it usually pays less for covered treatment furnished by a *non-preferred provider.*

When an *employee* enrolls in this *plan,* he or she and his or her dependents receive a dental plan ID card and information about current *preferred providers.*

A *covered person* must present his or her ID card when he or she uses a *preferred provider.* Most *preferred providers* prepare necessary claim forms for the *covered person,* and submit the forms to *us.* We send the *covered person* an explanation of this *plan's* benefit payments, but any benefit payable by us is sent directly to the *preferred provider.*

What *we* pay is based on all of the terms of this *plan.* Please read this *plan* carefully for specific benefit levels, deductibles, *payment rates* and *payment limits.*

A *covered person* may call the Guardian at the number shown on his or her ID card should he or she have any questions about this *plan.*

CGP-3-DGY2K-PPO B498.0151

Covered Charges

If a *covered person* uses the services of a *preferred provider,* covered charges are the charges listed in the fee schedule the *preferred provider* has agreed to accept as payment in full, for the dental services listed in this *plan's* List of Covered Dental Services.

If a *covered person* uses the services of a *non-preferred provider,* covered charges are reasonable and customary charges for the dental services listed in this *plan's* List of Covered Dental Services.

To be covered by this *plan,* a service must be: (a) necessary; (b) appropriate for a given condition; and (c) included in the List of Covered Dental Services.

We may use the professional review of a *dentist* to determine the appropriate benefit for a dental procedure or course of treatment.

By reasonable, *we* mean the charge is the *dentist's* usual charge for the service furnished. By customary, *we* mean the charge made for the given dental condition isn't more than the usual charge made by most other *dentists.* But, in no event will the covered charge be greater than the 80th percentile of the prevailing fee data for a particular service in a geographic area.

When certain comprehensive dental procedures are performed, other less extensive procedures may be performed prior to, at the same time or at a later date. For benefit purposes under this *plan,* these less extensive procedures are considered to be part of the more comprehensive procedure. Even if the *dentist* submits separate bills, the total benefit payable for all related charges will be limited to the maximum benefit payable for the more comprehensive procedure. For example, osseous surgery includes the procedure scaling and root planing. If the scaling and root planing is performed one or two weeks prior to the osseous surgery, we may only pay benefits for the osseous surgery.

We only pay benefits for covered charges incurred by a *covered person* while he or she is insured by this *plan.* A covered charge for a crown, bridge or cast restoration is incurred on the date the tooth is initially prepared. A covered charge for any other *dental prosthesis* is incurred on the date the first master impression is made. A covered charge for root canal treatment is incurred on the date the pulp chamber is opened. All other covered charges are incurred on the date the services are furnished. If a service is started while a *covered person* is insured, *we'll* only pay benefits for services which are completed within 31 days of the date his or her coverage under this *plan* ends.

Option A

Alternate Treatment

If more than one type of service can be used to treat a dental condition, *we* have the right to base benefits on the least expensive service which is within the range of professionally accepted standards of dental practice as determined by *us.* For example, in the case of bilateral multiple adjacent teeth, or multiple missing teeth in both quadrants of an arch, the benefit will be based on a removable partial denture.

Proof Of Claim

So that *we* may pay benefits accurately, the *covered person* or his or her *dentist* must provide *us* with information that is acceptable to *us.* This information may, at *our* discretion, consist of radiographs, study models, periodontal charting, narratives or other diagnostic materials that document *proof of claim* and support the necessity of the proposed treatment. If *we* don't receive the necessary information, *we* may pay no benefits, or minimum benefits. However, if *we* receive the necessary information within 15 months of the date of service, *we* will redetermine the *covered person's* benefits based on the new information.

Option A

Pre-Treatment Review

When the expected cost of a proposed course of treatment is $300.00 or more, the *covered person's dentist* should send us a treatment plan before he or she starts. This must be done on a form acceptable to *Guardian.* The treatment plan must include: (a) a list of the services to be done, using the American Dental Association Nomenclature and codes; (b) the itemized cost of each service; and (c) the estimated length of treatment. In order to evaluate the treatment plan, dental radiographs, study models and whatever else will document the necessity of the proposed course of treatment, must be sent to *us.*

We review the treatment plan and estimate what we will pay. We will send the estimate to the covered person and/or the covered person's dentist. If the treatment plan is not consistent with accepted standards of dental practice, or if one is not sent to us, we have the right to base our benefit payments on treatment appropriate to the covered person's condition using accepted standards of dental practice.

The covered person and his or her dentist have the opportunity to have services or a treatment plan reviewed before treatment begins. Pre-treatment review is not a guarantee of what we will pay. It tells the covered person, and his or her dentist, in advance, what we would pay for the covered dental services listed in the treatment plan. But, payment is conditioned on: (a) the services being performed as proposed and while the covered person is insured; and (b) the deductible, payment rate and payment limits provisions, and all of the other terms of this plan.

Pre-Treatment Review (Cont.)

Emergency treatment, oral examinations, evaluations, dental radiographs and teeth cleaning are part of a course of treatment, but may be done before the pre-treatment review is made.

We won't deny or reduce benefits if pre-treatment review is not done. But what we pay will be based on the availability and submission of proof of claim.

CGP-3-DGY2K-PTR B498.0004

Option A

Benefits From Other Sources

Other plans may furnish benefits similar to the benefits provided by this *plan.* For instance, you may be covered by this *plan* and a similar plan through your spouse's employer. You may also be covered by this *plan* and a medical plan. In such instances, we coordinate *our* benefits with the benefits from that other plan. *We* do this so that no one gets more in benefits than the charges he or she incurs. Read "Coordination of Benefits" to see how this works.

CGP-3-DGY2K-OS B498.0005

Option A

The Benefit Provision - Qualifying For Benefits

CGP-3-DGY2K-BEN B498.0072

Option A

Penalty For Late Entrants

During the first 6 months that a late entrant is covered by this *plan, we* won't pay for the following services:

- All Group II Services.

During the first 12 months a late entrant is covered by this *plan, we* won't pay for the following services:

- All Group III Services.

Charges for the services we don't cover under this provision are not considered to be covered charges under this *plan,* and therefore can't be used to meet this *plan's* deductibles.

We don't apply a late entrant penalty to covered charges incurred for services needed solely due to an *injury* suffered by a *covered person* while insured by this *plan.*

A late entrant is a person who: (a) becomes covered by this dental *plan* more than 31 days after he or she is eligible; or (b) becomes covered again, after his or her coverage lapsed because he or she did not make required payments.

CGP-3-DGY2K-LE B498.0232

Option A

How We Pay Benefits For Group I, II And III Non-Orthodontic Services

There is no deductible for Group I services. *We* pay for Group I covered charges at the applicable *payment rate.*

A *benefit year* deductible of $50.00 applies to Group II and III services provided by a *preferred provider.* A *benefit year* deductible of $50.00 applies to Group II and III services provided by a *non-preferred provider.* Each *covered person* must have covered charges from these service groups which exceed each applicable deductible before *we* pay him or her any benefits for such charges. These charges must be incurred while the *covered person* is insured.

Covered charges used to satisfy a *covered person's* Non-PPO deductible are also credited toward his or her PPO deductible. And covered charges used to satisfy a *covered person's* PPO deductible are also credited toward his or her Non-PPO deductible.

Once a *covered person* meets the deductible, *we* pay for his or her Group II and III covered charges above that amount at the applicable *payment rate* for the rest of that *benefit year.*

CGP-3-DGY2K-BP B498.0177

Option A

All covered charges must be incurred while insured. And we limit what we pay each benefit year to $2,000.00.

CGP-3-DGY2K-BP B498.0192

Option A

The Benefit Provision - Qualifying For Benefits

A *covered person* may be eligible for a rollover of a portion of his or her unused *benefit year* payment limit for Group I, II and III Non-Orthodontic Services. See "Rollover of Benefit Year Payment Limit for Group I, II and III Services" for details.

CGP-3-DG-ROLL-04-2.1 B498.2041

Option A

Rollover of Benefit Year Payment Limit for Group I, II and III Non-Orthodontic Services

A *covered person* may be eligible for a rollover of a portion of his or her unused *benefit year* payment limit for Group I, II and III Non-Orthodontic Services, as follows:

If a *covered person* submits at least one claim for covered charges during a *benefit year* and, in that *benefit year,* receives benefits that are in excess of any deductible or co-pay fees, and that, in total, do not exceed the *Rollover Threshold,* he or she may be entitled to a Reward.

Note: If all of the benefits that a *covered person* receives in a *benefit year* are for services provided by a *preferred provider,* he or she may be entitled to a greater *Reward* than if any of the benefits are for services of a *non-preferred provider.*

Rewards can accrue and are stored in the *covered person's Bank.* If a *covered person* reaches his or her *benefit year* payment limit for Group I, II and III Non-Orthodontic Services, we pay benefits up to the amount stored in the *covered person's Bank.* The amount of *Reward* stored in the *Bank* may not be greater than the *Bank Maximum.*

A *covered person's Bank* may be eliminated, and the accrued *Reward* lost, if he or she has a break in coverage of any length of time, for any reason.

The amounts of this *plan's Rollover Threshold, Reward,* and *Bank Maximum* are:

- *Rollover Threshold* $800.00
- *Reward* (if all benefits are for services provided by a *preferred provider)* $600.00
- *Reward* (if any benefits are for services provided by a *non-preferred provider)* $400.00
- *Bank Maximum* $1,500.00

If this *plan's* dental coverage first becomes effective in October, November or December, this rollover provision will not apply until January 1 of the first full *benefit year.* And, if the effective date of a *covered person's* dental coverage is in October, November or December, this rollover provision will not apply to the covered person until January 1 of the next full *benefit year.* In either case:

- only claims incurred on or after January 1 will count toward the *Rollover Threshold;* and
- *Rewards* will not be applied to a *covered person's Bank* until the *benefit year* that starts one year from the date the rollover provision first applies.

If charges for any dental services are not payable for a *covered person* for a period set forth in the provision of this *plan* called Penalty for Late Entrants and Waiting Periods for Certain Services, this rollover provision will not apply to the *covered person* until the end of such period. And, if such period ends within the three months prior to the start of this plan's next *benefit year,* this rollover provision will not apply to the *covered person* until the next *benefit year,* and:

- only claims incurred on or after the start of the next *benefit year* will count toward the *Rollover Threshold;* and
- *Rewards* will not be applied to a *covered person's Bank* until the *benefit year* that starts one year from the date the rollover provision first applies.

Definitions of terms used in this provision:

"Bank" means the amount of a *covered person's* accrued *Reward* .

"Bank Maximum" means the maximum amount of *Reward* that a *covered person* can store in his or her *Bank.*

"Reward" means the dollar amount which may be added to a *covered person's Bank* when he or she receives benefits in a *benefit year* that do not exceed the *Rollover Threshold.*

"Rollover Threshold" means the maximum amount of benefits that a *covered person* can receive during a *benefit year* and still be entitled to receive a *Reward.*

CGP-3-DG-ROLL-04-2 B498.2037

Option A

Non-Orthodontic Family Deductible Limit

A *covered family* must meet no more than three individual *benefit year* deductibles in any *benefit year.* Once this happens, *we* pay benefits for covered charges incurred by any *covered person* in that *covered family,* at the applicable *payment rate* for the rest of that *benefit year.* The charges must be incurred while the person is insured. What *we* pay is based on this *plan's payment limits* and to all of the terms of this *plan.*

CGP-3-DGY2K-FL B498.0073

Option A

Payment Rates

Benefits for covered charges are paid at the following *payment rates:*

- Benefits for Group I Services performed by a *preferred provider* 100%
- Benefits for Group I Services performed by a *non-preferred provider* 80%
- Benefits for Group II Services performed by a *preferred provider* 80%
- Benefits for Group II Services performed by a *non-preferred provider* 80%
- Benefits for Group III Services performed by a *preferred provider* 50%
- Benefits for Group III Services performed by a *non-preferred provider* 50%

CGP-3-DGY2K-PR B498.0078

Option A

After This Insurance Ends

We don't pay for charges incurred after a *covered person's* insurance ends. But, subject to all of the other terms of this *plan, we'll* pay for the following if the procedure is finished in the 31 days after a *covered person's* insurance under this *plan* ends: (a) a bridge or cast restoration, if the tooth or teeth are prepared before the *covered person's* insurance ends; (b) any other *dental prosthesis,* if the master impression is made before the *covered person's* insurance ends; and (c) root canal treatment, if the pulp chamber is opened before the *covered person's* insurance ends.

CGP-3-DGY2K-END B498.0234

Option A

Special Limitations

CGP-3-DGY2K-LMT B498.0138

Option A

Teeth Lost, Extracted Or Missing Before A Covered Person Becomes Covered By This Plan

A *covered person* may have one or more congenitally missing teeth or may have had one or more teeth lost or extracted before he or she became covered by this *plan. We* won't pay for a *dental prosthesis* which replaces such teeth unless the *dental prosthesis* also replaces one or more eligible natural teeth lost or extracted after the *covered person* became covered by this *plan.*

CGP-3-DGY2K-TL B498.0133

Option A

If This Plan Replaces The Prior Plan

This *plan* may be replacing the *prior plan* you had with another insurer. If a *covered person* was insured by the *prior plan* and is covered by this *plan* on its effective date, the following provisions apply to such *covered person.*

- **Teeth Extracted While Insured By The Prior Plan** - The "Teeth Lost, Extracted or Missing Before A Covered Person Becomes Covered By This Plan" provision above, does not apply to a *covered person's dental prosthesis* which replaces teeth: (a) that were extracted while the *covered person* was insured by the *prior plan;* and (b) for which extraction benefits were paid by the *prior plan.*

- **Deductible Credit** - In the first *benefit year* of this *plan,* we reduce a *covered person's* deductibles required under this *plan,* by the amount of covered charges applied against the *prior plan's* deductible. The *covered person* must give us proof of the amount of the *prior plan's* deductible which he or she has satisfied.

- ***Benefit Year* Non-Orthodontic Payment Limit Credit** - In the first *benefit year* of this *plan,* we reduce a *covered person's benefit year payment limits* by the amounts paid or payable under the *prior plan.* The *covered person* must give us proof of the amounts applied toward the *prior plan's* payment limits.

Option A

Exclusions

We will not pay for:

- Any service or supply which is not specifically listed in this *plan's* List of Covered Dental Services.

- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this *plan.*

- Educational services. This includes, but is not limited to: oral hygiene instruction; plaque control; tobacco counseling; or diet instruction.

- Precision attachments and the replacement of part of a precision attachment; magnetic retention; or overdenture attachments.

- Overdentures and related services. This includes root canal therapy on teeth that support an overdenture.

- Any restoration, procedure, or *appliance* or prosthetic device used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion, except to the extent that this *plan* covers *orthodontic treatment;* (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.

- The use of: general anesthesia; intramuscular sedation; intravenous sedation; non-intravenous sedation; or inhalation sedation, which includes but is not limited to nitrous oxide. But, this does not apply when administered in conjunction with: covered periodontal surgery; surgical extractions; the surgical removal of impacted teeth; apicoectomies; root amputations; and services listed under the "Other Oral Surgical Procedures" section of this *plan.*
- The use of local anesthetic.
- Cephalometric radiographs; oral/facial images. This includes traditional photographs and images obtained by intraoral camera. But, these services are covered when performed as part of the *orthodontic treatment* plan and records for a covered course of *orthodontic treatment.*
- Replacement of a lost, missing or stolen *appliance* or *dental prosthesis;* or the fabrication of a spare *appliance* or *dental prosthesis.*
- Prescription medication.
- Desensitizing medicaments; and desensitizing resins for cervical and/or root surface.
- Duplication of radiographs; the completion of claim forms; OSHA or other infection control charges.
- Pulp vitality tests; or caries susceptibility tests.
- Bite registration; or bite analysis.
- Gingival curettage.
- The localized delivery of chemotherapeutic agents.
- Tooth transplants.
- Maxillofacial prosthetics that repair or replace facial and skeletal anomalies; maxillofacial surgery; orthognathic surgery; or any oral surgery requiring the setting of a fracture or dislocation.
- Temporary or provisional *dental prosthesis* or *appliances.* But, this does not include interim partial dentures/stayplates to replace *anterior teeth* extracted while insured under this *plan.*
- Any service furnished solely for cosmetic reasons, unless the "List of Covered Dental Services" provides benefits for specific cosmetic services. Excluded cosmetic services include, but are not limited to: (1) characterization and personalization of a *dental prosthesis;* and (2) odontoplasty.
- Replacing an existing appliance or *dental prosthesis* with any *appliance* or prosthesis, unless it is: (1) at least 5 years old and is no longer usable; or (2) damaged while in the *covered person's* mouth in an *injury* suffered while insured, and can not be made serviceable.
- A fixed bridge replacing the extracted portion of a hemisected tooth; or the placement of more than one unit of crown and/or bridge per tooth.

- The replacement of extracted or missing third molars/wisdom teeth.
- Treatment of congenital or developmental malformations; or the replacement of congenitally missing teeth
- Any endodontic, periodontal, crown or bridge abutment procedure or *appliance* performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- Any procedure, *appliance, dental prosthesis,* modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ).
- Treatment needed due to: (1) an on-the-job or job-related *injury;* or (2) a condition for which benefits are payable by Workers' Compensation or similar laws.
- Treatment for which no charge is made. This usually means treatment furnished by: (1) the *covered person's* employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
- Evaluations and consultations for non-covered services; detailed and extensive oral evaluations.
- *Orthodontic treatment.*

CGP-3-DGY2K-EXCH-01 B498.2181

Option A

List of Covered Dental Services

The services covered by this *plan* are named in this list. Each service on this list has been placed in one of three groups. A separate payment rate applies to each group. Group I is made up of preventive services. Group II is made up of basic services. Group III is made up of major services.

All covered dental services must be furnished by or under the direct supervision of a *dentist.* And they must be usual and necessary treatment for a dental condition.

CGP-3-DNTL-90-13 B490.0148

Option A

Group I - Preventive Dental Services
(Non-Orthodontic)

Prophylaxis And Fluorides

Prophylaxis - limited to a total of 1 prophylaxis or periodontal maintenance procedure (considered under "Periodontal Services") in any 6 consecutive month period. Allowance includes scaling and polishing procedures to remove coronal plaque, calculus, and stains.

- Adult prophylaxis covered age 12 and older.

Additional prophylaxis when needed as a result of a medical (i.e., a non-dental) condition - covered once in 12 months, and only when the additional prophylaxis is recommended by the dentist and is a result of a medical condition as verified in writing by the patient's medical physician. This does not include a condition which could be resolved by proper oral hygiene or that is the result of patient neglect.

Fluoride treatment, topical application - limited to *covered persons* under age 14 and limited to 1 treatment(s) in any 6 consecutive month period.

Office Visits, Evaluations And Examination

Office visits, oral evaluations, examinations or limited problem focused re-evaluations - limited to a total of 1 in any 6 consecutive month period.

Emergency or problem focused oral evaluation - limited to a total of 1 in a 6 consecutive month period. Covered if no other treatment, other than radiographs, is performed in the same visit.

After hours office visit or emergency palliative treatment and other non-routine, unscheduled visits. Limited to a total of 1 in a 6 consecutive month period. Covered only when no other treatment, other than radiographs, is performed during the same visit.

Option A

Space Maintainers

Space Maintainers - limited to *covered persons* under age 16 and limited to initial *appliance* only. Covered only when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes all adjustments in the first six months after insertion, limited to a maximum of one bilateral per arch or one unilateral per quadrant, per lifetime.

- Fixed - unilateral
- Fixed - bilateral
- Removable - bilateral
- Removable - unilateral

Recementation of space maintainer performed more than 12 months after the initial insertion

Fixed And Removable Appliances

Fixed and Removable Appliances To Inhibit Thumbsucking - limited to *covered persons* under age 14 and limited to initial *appliance* only. Allowance includes all adjustments in the first 6 months after insertion.

Option A

Radiographs Allowance includes evaluation and diagnosis.
Full mouth, complete series or panoramic radiograph - Either, but not both, of the following procedures, limited to one in any 60 consecutive month period.

Full mouth series, of at least 14 films including bitewings
Panoramic film, maxilla and mandible, with or without bitewing radiographs.

Other diagnostic radiographs:

Bitewing films - limited to either a maximum of 4 bitewing films or a set (7-8 films) of vertical bitewings, in one visit, once in any 12 consecutive month period.

Intraoral periapical or occlusal films - single films

CGP-3-DNTL-90-14 B498.0165

Option A

Dental Sealants Dental Sealants - permanent molar teeth only - Topical application of sealants is limited to the unrestored, permanent molar teeth of *covered persons* under age 16 and limited to one treatment, per tooth, in any 36 consecutive month period.

CGP-3-DNTL-90-14 B498.0166

Option A

Group II - Basic Dental Services
(Non-Orthodontic)

Diagnostic Services Allowance includes examination and diagnosis.

Consultations - Diagnostic consultation with a dentist other than the one providing treatment, limited to one consultation for each *covered dental specialty* in any 12 consecutive month period. Covered only when no other treatment, other than radiographs, is performed during the visit.

Diagnostic Services: Allowance includes examination and diagnosis.

Diagnostic casts - when needed to prepare a treatment plan for three or more of the following performed at the same time in more than one arch: dentures, crowns, bridges, inlays or onlays.

Histopathologic examinations when performed in conjunction with a tooth related biopsy.

Restorative Services

Multiple restorations on one surface will be considered one restoration. Benefits for the replacement of existing amalgam and resin restorations will only be considered for payment if at least 12 months have passed since the previous restoration was placed if the *covered person* is under age 19, and 36 months if the *covered person* is age 19 and older. Also see the "Major Restorative Services" section.

Amalgam restorations - Allowance includes bonding agents, liners, bases, polishing and local anesthetic.

Resin restorations - Allowance includes light curing, acid etching, adhesives, including resin bonding agents and local anesthetic. Restorations on *anterior teeth* that do not involve the incisal edge are considered a single surface filling.

Silicate cement, per restoration
Composite resin

Stainless steel prefabricated resin, and resin based composite - limited to once per tooth in any 24 consecutive month period. Stainless steel, prefabricated resin and resin based composite crowns are considered to be a temporary or provisional procedure when done within 24 months of a permanent crown. Temporary and provisional crowns are considered to be part of the permanent restoration.

Pin retention, per tooth, covered only in conjunction with a permanent amalgam or composite restoration, exclusive of restorative material.

CGP-3-DNTL-90-15 B498.1145

Option A

Crown And Prosthodontic Restorative Services

Also see the "Major Restorative Services" section.

Crown and bridge repairs - allowance based on the extent and nature of damage and the type of material involved.

Recementation, limited to recementations performed more than 12 months after the initial insertion.

Inlay or onlay
Crown
Bridge

Adding teeth to partial dentures to replace extracted natural teeth

Denture repairs - Allowance based on the extent and nature of damage and on the type of materials involved.

Denture repairs, metal
Denture repairs, acrylic
Denture repair, no teeth damaged
Denture repair, replace one or more broken teeth
Replacing one or more broken teeth, no other damage

Denture rebase, full or partial denture - limited to once per denture in any 24 consecutive month period. Denture rebases done within 12 months are considered to be part of the denture placement when the rebase is done by the *dentist* who furnished the denture. Limited to rebase done more than 12 consecutive months after the insertion of the denture.

Denture reline, full or partial denture - limited to once per denture in any 24 consecutive month period. Denture relines done within 12 months are considered to be part of the denture placement when the reline is done by the *dentist* who furnished the denture. Limited to reline done more than 12 consecutive months after a denture rebase or the insertion of the denture.

Denture adjustments - Denture adjustments done within 6 months are considered to be part of the denture placement when the adjustment is done by the *dentist* who furnished the denture. Limited to adjustments that are done more than 6 consecutive months after a denture rebase, denture reline or the initial insertion of the denture.

Tissue conditioning - Tissue conditioning done within 12 months is considered to be part of the denture placement when the tissue conditioning is done by the *dentist* who furnished the denture. Limited to a maximum of 1 treatment, per arch, in any 12 consecutive month period.

CGP-3-DNTL-90-15 B498.1122

Option A

Endodontic Services

Allowance includes diagnostic, treatment and final radiographs, cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration.

Pulp capping, limited to permanent teeth and limited to one pulp cap per tooth, per lifetime.
- Pulp capping, direct
- Pulp capping, indirect - includes sedative filling.

Vital pulpotomy, only when root canal therapy is not the definitive treatment
Gross pulpal debridement
Pulpal therapy, limited to primary teeth only
Root Canal Treatment
- Root canal therapy
- Root canal retreatment, limited to once per tooth, per lifetime
- Treatment of root canal obstruction, no-surgical access
- Incomplete endodontic therapy, inoperable or fractured tooth
- Internal root repair of perforation defects

Other Endodontic Services
- Apexification, limited to a maximum of three visits
- Apicoectomy, limited to once per root, per lifetime
- Root amputation, limited to once per root, per lifetime
- Retrograde filling, limited to once per root, per lifetime
- Hemisection, including any root removal, once per tooth

CGP-3-DNTL-90-15.0 B498.0201

Option A

Periodontal Services

Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved.

Periodontal maintenance procedure - limited to a total of 1 prophylaxis or periodontal maintenance procedure(s) in any 6 consecutive month period. Allowance includes periodontal pocket charting, scaling and polishing. (Also see Prophylaxis under "Preventive Services") Coverage for periodontal maintenance is considered upon evidence of completed active periodontal therapy (periodontal scaling and root planing or periodontal surgery).

Scaling and root planing, per quadrant - limited to once per quadrant in any 24 consecutive month period. Covered when there is radiographic and pocket charting evidence of bone loss.

Full mouth debridement - limited to once in any 36 consecutive month period. Considered only when no diagnostic, preventive, periodontal service or periodontal surgery procedure has been performed in the previous 36 consecutive month period.

Option A

Periodontal Surgery

Allowance includes the treatment plan, local anesthetic and post-surgical care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved.

The following treatment is limited to a total of one of the following, once per tooth in any 12 consecutive months.

Gingivectomy, per tooth (less than 3 teeth)
Crown lengthening - hard tissue

The following treatment is limited to a total of one of the following once per quadrant, in any 36 consecutive months.

Gingivectomy or gingivoplasty, per quadrant
Osseous surgery, including scaling and root planing, flap entry and closure, per quadrant
Gingival flap procedure, including scaling and root planing, per quadrant
Distal or proximal wedge, not in conjunction with osseous surgery
Surgical revision procedure, per tooth

The following treatment is limited to a total of one of the following, once per quadrant in any 36 consecutive months.

Pedicle or free soft tissue grafts, including donor site, or subepithelial connective tissue graft procedure, when the tooth is present, or when dentally necessary as part of a covered surgical placement of an implant.

The following treatment is limited to a total of one of the following, once per area or tooth, per lifetime.

Guided tissue regeneration, resorbable barrier or nonresorbable barrier
Bone replacement grafts, when the tooth is present

Periodontal surgery related

Limited occlusal adjustment - limited to a total of two visits, covered only when done within a 6 consecutive month period after covered scaling and root planing or osseous surgery. Must have radiographic evidence of vertical defect or widened periodontal ligament space.

Occlusal guards, covered only when done within a 6 consecutive month period after osseous surgery, and limited to one per lifetime

CGP-3-DNTL-90-15.0 B498.0203

Option A

Non-Surgical Extractions

Allowance includes the treatment plan, local anesthetic and post-treatment care.

Uncomplicated extraction, one or more teeth
Root removal - non-surgical extraction of exposed roots

CGP-3-DNTL-90-15.0 B498.0204

Option A

Other Services

General anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, including nitrous oxide, when administered in connection with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations, surgical placement of an implant and services listed under the "Other Oral Surgical Procedures" section of this *plan.*

Injectable antibiotics needed solely for treatment of a dental condition.

CGP-3-DNTL-90-15 B498.0206

Group III - Major Dental Services
(Non-Orthodontic)

Major Restorative Services

Crowns, inlays, onlays, labial veneers, and crown buildups are covered only when needed because of decay or *injury,* and only when the tooth cannot be restored with amalgam or composite filling material. Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. Post and cores are covered only when needed due to decay or *injury.* Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only. Also see the "Basic Restorative Services" section.

Single Crowns
- Resin with metal
- Porcelain
- Porcelain with metal
- Full cast metal (other than stainless steel)
- 3/4 cast metal crowns
- 3/4 porcelain crowns

Inlays
Onlays, including inlay
Labial veneers

Posts and buildups - only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure.

- Cast post and core in addition to a unit of crown or bridge, per tooth
- Prefabricated post and composite or amalgam core in addition to a unit of crown or bridge, per tooth
- Crown or core buildup, including pins

Implant supported prosthetics - Allowance includes the treatment plan and local anesthetic, when done in conjunction with a covered surgical placement of an implant, on the same tooth.
- Abutment supported crown
- Implant supported crown
- Abutment supported retainer for fixed partial denture
- Implant supported retainer for fixed partial denture
- Implant/abutment supported removable denture for completely edentulous arch
- Implant/abutment supported removable denture for partially edentulous arch
- Implant/abutment supported fixed denture for completely edentulous arch
- Implant/abutment supported fixed denture for partially edentulous arch
- Dental implant supported connecting bar
- Prefabricated abutment
- Custom abutment

Implant services - Allowance includes the treatment plan, local anesthetic and post-surgical care. Limited to the replacement of permanent teeth only. The number of implants we cover is limited to the number of teeth extracted while insured under this plan.

Surgical placement of implant body, endosteal implant
Surgical placement, eposteal implant
Surgical placement, transosteal implant

Other Implant services

Bone replacement graft for ridge preservation, per site, when done in conjunction with a covered surgical placement of an implant in the same site, limited to once per tooth, per lifetime
Radiographic/surgical implant index - limited to once per arch in any 24 month period
Repair implant supported prosthesis
Repair implant abutment
Implant removal

Option A

Prosthodontic Services

Specialized techniques and characterizations are not covered. Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement.

Fixed bridges - Each abutment and each pontic makes up a unit in a bridge

Bridge abutments - See inlays, onlays and crowns under "Major Restorative Services"

Bridge Pontics
Resin with metal
Porcelain
Porcelain with metal
Full cast metal
3/4 cast metal crowns
3/4 porcelain crowns

Dentures - Allowance includes all adjustments and repairs done by the *dentist* furnishing the denture in the first 6 consecutive months after installation and all temporary or provisional dentures. Temporary or provisional dentures, stayplates and interim dentures older than one year are considered to be a permanent *appliance.*

Complete or Immediate dentures, upper or lower

Partial dentures - Allowance includes base, clasps, rests and teeth

Upper, resin base, including any conventional clasps, rests and teeth

Upper, cast metal framework with resin denture base, including any conventional clasps, rests and teeth

Lower, resin base, including any conventional clasps, rests and teeth

Lower, cast metal framework with resin denture base, including any conventional clasps, rests and teeth

Interim partial denture (stayplate), upper or lower, covered on anterior teeth only

Removable unilateral partial, one piece cast metal, including clasps and teeth

Simple stress breakers, per unit

Option A

Surgical Extractions

Allowance includes the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by your medical plan.

Surgical removal of erupted teeth, involving tissue flap and bone removal
Surgical removal of residual tooth roots
Surgical removal of impacted teeth

Other Oral Surgical Procedures

Allowance includes diagnostic and treatment radiographs, the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by your medical plan.

Alveoloplasty, per quadrant
Removal of exostosis, per site
Incision and drainage of abscess
Frenulectomy, Frenectomy, Frenotomy
Biopsy and examination of tooth related oral tissue
Surgical exposure of impacted or unerupted tooth to aid eruption
Excision of tooth related tumors, cysts and neoplasms
Excision or destruction of tooth related lesion(s)
Excision of hyperplastic tissue
Excision of pericoronal gingiva, per tooth
Oroantral fistula closure
Sialolithotomy
Sialodochoplasty
Closure of salivary fistula
Excision of salivary gland
Maxillary sinusotomy for removal of tooth fragment or foreign body
Vestibuloplasty

CERTIFICATE AMENDMENT

Effective on the first policy anniversary on or after January 1, 2011 the certificate is amended as follows:

The Life Insurance eligibility provisions applicable to dependent coverage are changed so that a dependent child means your child under age 26. The dependent eligibility provisions are further modified so that marital status, residency and financial dependency requirements do not apply to your dependent child.

But your child who is no longer eligible for coverage under the policy due to the policy's prior dependent age limitations, may be eligible to enroll for coverage under the policy subject to all the terms and conditions below.

To be eligible for such coverage under the policy, your child (i) must be less than 26 years of age; (ii) must not be eligible for similar coverage through an employer sponsored policy; other than the policy of the parent and (iii) must make a written election for such coverage as a dependent:

(a) During the special open enrollment period which starts 30 days prior to the Policy's first Policy Anniversary on or after January 1, 2011, if he or she enrolls during this special open enrollment period his or her coverage is scheduled to start on the Policy Anniversary Date.

(b) After the open enrollment period, if he or she enrolls within 30 days of his or her eligibility date his or her coverage is scheduled to start on the date his or her enrollment form is signed and dated. If he or she does this more than 30 days after the Policy Anniversary Date he or she is considered a late enrollee and is subject to this coverage's limitations for late enrollee. Such coverage will start on the date set forth in the Policy's eligibility provisions. To the extent the policy provides coverage with respect to a dependent child age 26 or older such provisions will continue to apply.

All terms and conditions of your certificate not specifically changed herein remain in full force and effect.

The Guardian Life Insurance Company of America

Stuart J Shaw

Vice President, Risk Mgt. & Chief Actuary

CGP-1-A B531.0018

CERTIFICATE AMENDMENT

(To be attached to certificates issued to employees) The certificate is amended as follows:

This plan's Employee Basic Life "Settlement Option" provision of the Life Certificate is modified as follows:

Settlement Option: Unless otherwise elected by the certificate holder or beneficiary, benefits will be paid in a single lump sum check. We may make other options available in addition to the single check option.

This rider is part of this certificate. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this certificate.

The Guardian Life Insurance Company of America

Stuart J Shaw

Vice President, Risk Mgt. & Chief Actuary

CGP-1-A B531.0114

CERTIFICATE AMENDMENT

(To be attached to certificates issued to employees) The certificate is amended as follows:

This plan's Employee and Dependent Optional Life "Settlement Option" provision is modified as follows:

Settlement Option: Unless otherwise elected by the certificate holder or beneficiary, benefits will be paid in a single lump sum check. We may make other options available in addition to the single check option.

This rider is part of this certificate. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this certificate.

The Guardian Life Insurance Company of America

Stuart J Shaw

Vice President, Risk Mgt. & Chief Actuary

CGP-1-A B531.0117

COORDINATION OF BENEFITS

Important Notice This section applies to all group health benefits under this plan; except prescription drug and vision coverage, if any. It does not apply to any death, dismemberment, or loss of income benefits that may be provided under this plan.

Purpose When a covered person has health care coverage under more than one plan, this section allows this plan to coordinate what it pays with what other plans pay. This is done so that the covered person does not collect more in benefits than he or she incurs in charges.

Definitions

Allowable Expense This term means any necessary, reasonable, and customary item of health care expense that is covered, at least in part, by any of the plans which cover the person. This includes: (a) deductibles; (b) coinsurance; and (c) copayments. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

An expense or service that is not covered by any of the plans is **not** an allowable expense. Examples of other expenses or services that are **not** allowable expenses are:

(1) If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is **not** an allowable expense. This does not apply if: (a) the stay in the private room is medically necessary in terms of generally accepted medical practice; or (b) one of the plans routinely provides coverage for private hospital rooms.

(2) The amount a benefit is reduced by the primary plan because a person does not comply with the plan's provisions is **not** an allowable expense. Examples of these provisions are: (a) precertification of admissions and procedures; (b) continued stay reviews; and (c) preferred provider arrangements.

(3) If a person is covered by two or more plans that compute their benefit payments on the basis of reasonable and customary charges, any amount in excess of the primary plan's reasonable and customary charges for a specific benefit is **not** an allowable expense.

(4) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the primary plan's negotiated fees for a specific benefit is **not** an allowable expense.

If a person is covered by one plan that computes its benefits or services on the basis of reasonable and customary charges and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements will be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefit.

Claim This term means a request that benefits of a plan be provided or paid.

Claim Determination Period This term means a calendar year. It does not include any part of a year during which a person has no coverage under this plan, or before the date this section takes effect.

Coordination Of Benefits This term means a provision which determines an order in which plans pay their benefits, and which permits secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

Custodial Parent This term means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Plan This term means any of the following that provides benefits or services for health care or treatment: (1) group, blanket or franchise insurance coverage; (2) service plan contracts, group practice, individual practice and other prepayment coverage; (3) any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans; and (4) governmental benefits, except Medicare, as permitted by law.

This term does not include: (a) individual or family insurance; (b) individual or family subscriber contracts; (c) school-type blanket accident and sickness insurance; (d) blanket accident insurance that is excess to other coverage; (e) medical benefit payments in traditional automobile contracts; or (f) Medicare, Medicaid, and coverage under other governmental plans, unless permitted by law.

This term also does not include any plan that this plan supplements. Plans that this plan supplements are named in the benefit description.

Each type of coverage listed above is treated separately. If a plan has two parts and coordination of benefits applies only to one of the two, each of the parts is treated separately.

Primary Plan This term means a plan that pays first without regard that another plan may cover some expenses. A plan is a primary plan if either of the following is true: (1) the plan either has no order of benefit determination rules, or its rules differ from those explained in this section; or (2) all plans that cover the person use the order of benefit determination rules explained in this section, and under those rules the plan pays its benefits first.

Secondary Plan This term means a plan that is not a primary plan.

This Plan This term means the group health benefits, except prescription drug and vision coverage, if any, provided under this group plan.

CGP-3-R-COB-05 B555.0293

Option A

Order Of Benefit Determination

The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

A plan may consider the benefits paid or provided by another plan to determine its benefits only when it is secondary to that other plan. If a person is covered by more than one secondary plan, the rules explained below decide the order in which secondary plan benefits are determined in relation to each other.

A plan that does not contain a coordination of benefits provision is always primary.

When all plans have coordination of benefits provisions, the rules to determine the order of payment are listed below. The first of the rules that applies is the rule to use.

Non-Dependent Or Dependent The plan that covers the person other than as a dependent (for example, as an employee, member, subscriber, or retiree) is primary. The plan that covers the person as a dependent is secondary.

But, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan that covers the person as a dependent; and primary to the plan that covers the person other than as a dependent (for example, as a retiree); then the order of payment between the two plans is reversed. In that case, the plan that covers the person as an employee, member, subscriber, or retiree is secondary and the other plan is primary.

Child Covered Under More Than One Plan The order of benefit determination when a child is covered by more than one plan is:

(1) If the parents are married, or are not separated (whether or not they ever have been married), or a court decree awards joint custody without specifying that one party must provide health care coverage, the plan of the parent whose birthday is earlier in the year is primary. If both parents have the same birthday, the plan that covered either of the parents longer is primary. If a plan does not have this birthday rule, then that plan's coordination of benefits provision will determine which plan is primary.

(2) If the specific terms of a court decree state that one of the parents must provide health care coverage and the plan of the parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods that start after the plan is given notice of the court decree.

(3) In the absence of a court decree, if the parents are not married, or are separated (whether or not they ever have been married), or are divorced, the order of benefit determination is: (a) the plan of the custodial parent; (b) the plan of the spouse of the custodial parent; (c) the plan of the noncustodial parent; and (d) the plan of the spouse of the noncustodial parent.

Active Or Inactive Employee The plan that covers a person as an active employee, or as that person's dependent, is primary. An active employee is one who is neither laid off nor retired. The plan that covers a person as a laid off or retired employee, or as that person's dependent, is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.

Continuation Coverage The plan that covers a person as an active employee, member, subscriber, or retired employee, or as that person's dependent, is primary. The plan that covers a person under a right of continuation provided by federal or state law is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.

Length Of Coverage The plan that covered the person longer is primary.

Other If the above rules do not determine the primary plan, the allowable expenses will be shared equally between the plans that meet the definition of plan under this section. But, this plan will not pay more than it would have had it been the primary plan.

CGP-3-R-COB-05 B555.0295

Option A

Effect On The Benefits Of This Plan

When This Plan Is Primary When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits.

When This Plan Is Secondary When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses. When the benefits of this plan are reduced, each benefit is reduced in proportion. It is then charged against the applicable benefit limit of this plan.

Right To Receive And Release Needed Information

Certain facts about health care coverage and services are needed to apply these rules and to determine benefits payable under this plan and other plans. This plan may get the facts it needs from, or give them to, other organizations or persons to apply these rules and determine benefits payable under this plan and other plans which cover the person claiming benefits. This plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must provide any facts it needs to apply these rules and determine benefits payable.

Facility Of Payment

A payment made under another plan may include an amount that should have been paid by this plan. If it does, this plan may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid by this plan. This plan will not have to pay that amount again.

As used here, the term "payment made" includes the reasonable cash value of any benefits provided in the form of services.

Right Of Recovery

If the amount of the payments made by this plan is more than it should have paid under this section, it may recover the excess: (a) from one or more of the persons it has paid or for whom it has paid; or (b) from any other person or organization that may be responsible for benefits or services provided for the covered person.

As used here, the term "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Option A

CERTIFICATE AMENDMENT

Notwithstanding any provision in the Plan to the contrary, it is hereby agreed that the Group Plan is amended January 1, 2003 so that,

(A) A Covered Person may select any holder of a license issued under Section 2135, 1000, 1634 or 2948 of the California Business and Professions Code, to perform any Covered service such holder is expressly authorized by law to perform.

(B) A Covered Person may select a clinical social worker who is the holder of a license issued under Section 9040 of the California Business and Professions Code, to perform any covered service which such social worker is expressly authorized by law to perform, provided such Covered Person is referred to such social worker by a licensed physician or surgeon.

(C) A Covered Person may select an occupational therapist, regulated under Section 2570 of the California Business and Professions Code to perform any covered service which such Occupational Therapist is expressly authorized by law to perform, provided such Covered Person is referred to such occupational therapist by a licensed physician or surgeon.

(D) A Covered Person may select a speech pathologist or audiologist, licensed under section 2530 of the California Business and Professions Code, to perform any covered service which such speech pathologist or audiologist is expressly authorized by law to perform, provided such Covered Person is referred to such speech pathologist of audiologist by a licensed physician or surgeon.

(E) A Covered Person may select a marriage, family, and child counselor, licensed under Section 17805 of the California Business and Professions Code, to perform any covered service which such family, marriage, and child counselor is expressly authorized by law to perform, provided Covered Person is referred to such family, marriage, and child counselor by a licensed physician or surgeon.

This Rider shall form a part of the Policy, Except as stated in this Rider, nothing contained herein shall be held to alter or affect any of the provisions of the policy, including any prior Riders, Amendments, or Endorsements.

All terms and conditions of your certificate, not specifically changed herein, remain in full force and effect.

The Guardian Life Insurance Company of America

Stuart J Shaw

Vice President, Risk Mgt. & Chief Actuary

CGP-1-A-CAL-PR B590.9027

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

CGP-3-GLOSS-90 B900.0118

Option A

Anterior Teeth means the incisor and cuspid teeth. The teeth are located in front of the bicuspids (pre-molars).

CGP-3-GLOSS-90 B750.0664

Option A

Appliance means any dental device other than a *dental prosthesis.*

CGP-3-GLOSS-90 B750.0665

Option A

Benefit Year means a 12 month period which starts on January 1st and ends on December 31st of each year.

CGP-3-GLOSS-90 B750.0666

Option A

Covered Dental Specialty means any group of procedures which falls under one of the following categories, whether performed by a specialist *dentist* or a general *dentist:* restorative/prosthodontic services; endodontic services, periodontic services, oral surgery and pedodontics.

CGP-3-GLOSS-90 B750.0667

Option A

Covered Family means an employee and those of his or her dependents who are covered by this *plan.*

CGP-3-GLOSS-90 B750.0668

Option A

Covered Person means an employee or any of his or her covered dependents.

CGP-3-GLOSS-90 B750.0669

Option A

Dental Prosthesis means a restorative service which is used to replace one or more missing or lost teeth and associated tooth structures. It includes all types of abutment crowns, inlays and onlays, bridge pontics, complete and immediate dentures, partial dentures and unilateral partials. It also includes all types of crowns, veneers, inlays, onlays, implants and posts and cores.

CGP-3-GLOSS-90 B750.0670

Option A

Dentist means any dental or medical practitioner we are required by law to recognize who: (a) is properly licensed or certified under the laws of the state where he or she practices; and (b) provides services which are within the scope of his or her license or certificate and covered by this *plan.*

CGP-3-GLOSS-90 B750.0671

All Options

Eligibility Date for dependent coverage is the earliest date on which: (a) you have initial dependents; and (b) are eligible for dependent coverage.

CGP-3-GLOSS-90 B900.0003

All Options

Eligible Dependent is defined in the provision entitled "Dependent Coverage."

CGP-3-GLOSS-90 B750.0015

Option A

Emergency Treatment means bona fide emergency services which: (a) are reasonably necessary to relieve the sudden onset of severe pain, fever, swelling, serious bleeding, severe discomfort, or to prevent the imminent loss of teeth; and (b) are covered by this *plan.*

CGP-3-GLOSS-90 B750.0672

All Options

Employee means a person who works for the *employer* at the *employer's* place of business, and whose income is reported for tax purposes using a W-2 form.

CGP-3-GLOSS-90 B750.0006

All Options

Employer means SULLIVAN CURTIS MONROE .

CGP-3-GLOSS-90 B900.0051

All Options

Enrollment Period with respect to dependent coverage, means the 31 day period which starts on the date that you first become eligible for dependent coverage.

CGP-3-GLOSS-90 B900.0004

All Options

Full-time means the *employee* regularly works at least the number of hours in the normal work week set by the *employer* (but not less than 30 hours per week), at his *employer's* place of business.

CGP-3-GLOSS-90 B750.0229

All Options

Initial Dependents means those *eligible dependents* you have at the time you first become eligible for *employee* coverage. If at this time you do not have any *eligible dependents,* but you later acquire them, the first *eligible dependents* you acquire are your *initial dependents.*

CGP-3-GLOSS-90 B900.0006

Option A

Injury means all damage to a *covered person's* mouth due to an accident which occurred while he or she is covered by this *plan,* and all complications arising from that damage. But the term *injury* does not include damage to teeth, *appliances* or *dental prostheses* which results solely from chewing or biting food or other substances.

CGP-3-GLOSS-90 B750.0673

All Options

Newly Acquired Dependent means an *eligible dependent* you acquire after you already have coverage in force for *initial dependents.*

CGP-3-GLOSS-90 B900.0008

Option A

Non-Preferred Provider means a *dentist* or dental care facility that is not under contract with DentalGuard Preferred as a *preferred provider.*

CGP-3-GLOSS-90 B750.0674

Option A

Orthodontic Treatment means the movement of one or more teeth by the use of *active appliances.* it includes: (a) treatment plan and records, including initial, interim and final records; (b) periodic visits, limited orthodontic treatment, interceptive orthodontic treatment and comprehensive orthodontic treatment, including fabrication and insertion of any and all fixed appliances; (c) orthodontic retention, including any and all necessary fixed and removable appliances and related visits. This *plan* does not pay benefits for *orthodontic treatment.*

CGP-3-GLOSS-90 B750.0685

Option A

Payment Limit means the maximum amount this *plan* pays for covered services during either a *benefit year* or a *covered person's* lifetime, as applicable.

CGP-3-GLOSS-90 B750.0676

Option A

Payment Rate means the percentage rate that this *plan* pays for covered services.

CGP-3-GLOSS-90 B750.0677

Option A

Posterior Teeth means the bicuspid (pre-molars) and molar teeth. These are the teeth located behind the cuspids.

CGP-3-GLOSS-90 B750.0679

Option A

Plan means the Guardian group dental plan purchased by the planholder.

CGP-3-GLOSS-90 B750.0678

Option B

Plan means the *Guardian* group *plan* purchased by your *employer,* except in the provision entitled "Coordination of Benefits" where "plan" has a special meaning. See that provision for details.

CGP-3-GLOSS-90 B900.0039

Option A

Preferred Provider means a *dentist* or dental care facility that is under contract with DentalGuard Preferred as a preferred provider.

CGP-3-GLOSS-90 B750.0680

Option A

Prior Plan means the planholder's plan or policy of group dental insurance which was in force immediately prior to this *plan.* To be considered a prior plan, this *plan* must start immediately after the prior coverage ends.

CGP-3-GLOSS-90 B750.0681

Option A

Proof Of Claim means dental radiographs, study models, periodontal charting, written narrative or any documentation that may validate the necessity of the proposed treatment.

CGP-3-GLOSS-90 B750.0682

All Options

Proof or Proof of Insurability means an application for insurance showing that a person is insurable.

CGP-3-GLOSS-90 B900.0010

Option A

We, Us, Our And Guardian mean The Guardian Life Insurance Company of America.

CGP-3-GLOSS-90 B750.0683

SUMMARY PLAN DESCRIPTION SUPPLEMENT TO CERTIFICATE

You participate in a single employer insured Welfare Plan. This supplement and your certificate of insurance constitute the Summary Plan Description as required by the Employee Retirement Income Security Act of 1974 (ERISA). This supplement should be retained with your certificate.

- **Name of Plan:**

  SULLIVAN CURTIS MONROE GROUP INSURANCE PLAN

- **Employer's Name:** (Plan Sponsor)

  SULLIVAN CURTIS MONROE

  Address: 1920 MAIN STREET NO 600

  IRVINE CA 92614

  Phone Number: 949-852-4803

- **IRS Employer Identification Number (EIN):** 944076864

- **Plan Number:** 501

- **Plan Administrator:** (if other than Plan Sponsor)

  SULLIVAN CURTIS MONROE

  Address: 1920 MAIN STREET NO 600

  IRVINE CA 92614

  Phone Number: 949-852-4803

- **Agent for The Service of Legal Process:**

  SULLIVAN CURTIS MONROE

  Address: 1920 MAIN STREET NO 600

  IRVINE CA 92614

  (Legal process may also be served on the Plan Administrator.)

- **Date of End of Plan Year:** One day prior to January 1st .

- Contributions to the plan are provided by the Employer and the Employee.

- The following class or classes of full-time employees are eligible to apply for insurance:

Class 0001 ALL OTHER ELIGIBLE EMPLOYEES

provided they have completed the service waiting period established by the employer, if any. Qualified dependents of these employees may also be eligible for insurance. (Your certificate provides details).

B800.0047

STATEMENT OF ERISA RIGHTS

As a participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

(a) Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

(b) Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

(c) Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. You should review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcement Of Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a state or Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110.00 a day until you receive the material, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance with Questions

If you have questions about the plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Qualified Medical Child Support Order

Federal law requires that group health plans provide medical care coverage of a dependent child pursuant to a qualified medical child support order (QMCSO). A "qualified medical child support order" is a judgment or decree issued by a state court that requires a group medical plan to provide coverage to the named dependent child(ren) of an employee pursuant to a state domestic relations order. For the order to be qualified it must include:

- The name of the group health plan to which it applies.
- The name and last known address of the employee and the child(ren).
- A reasonable description of the type of coverage or benefits to be provided by the plan to the child(ren).
- The time period to which the order applies.

A dependent enrolled due to a QMCSO will not be considered a late enrollee in the plan.

Note: A QMCSO cannot require a group health plan to provide any type or form of benefit or option not otherwise available under the plan except to the extent necessary to meet medical child support laws described in Section 90 of the Social Security Act.

If you have questions about this statement, see the plan administrator.

B800.0094

All Options

The Guardian's Responsibilities

B800.0048

Option A

The dental expense benefits provided by this plan are guaranteed by a policy of insurance issued by The Guardian. The Guardian also supplies administrative services, such as claims services, including the payment of claims, preparation of employee certificates of insurance, and changes to such certificates.

B800.0053

All Options

The Guardian is located at 7 Hanover Square, New York, New York 10004.

B800.0049

Disability And Group Health Benefits Claims Procedure

If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from the Plan Administrator.

Guardian is the Claims Fiduciary with discretionary authority to determine eligibility for benefits and to construe the terms of the *plan* with respect to claims. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of the Employee Retirement Income Security Act of 1974 ("ERISA")

Definitions

"Adverse determination" means any denial, reduction or termination of a benefit or failure to provide or make payment (in whole or in part) for a benefit. A failure to cover an item or service: (a) due to the application of any utilization review; or (b) because the item or service is determined to be experimental or investigational, or not medically necessary or appropriate, is also considered an adverse determination.

"Group Health Benefits" means any dental, out-of-network point-of-service medical, major medical, vision care or prescription drug coverages which are a part of this plan.

"Pre-service claim" means a claim for a medical care benefit with respect to which the plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of receipt of care.

"Post-service claim" means a claim for payment for medical care that already has been provided.

"Urgent care claim" means a claim for medical care or treatment where making a non- urgent care decision: (a) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, as determined by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; or (b) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care.

Note: Any claim that a physician with knowledge of the claimant's medical condition determines is a claim involving urgent care will be treated as an urgent care claim for purposes of this section.

Timing For Initial Benefit Determination

The benefit determination period begins when a claim is received. Guardian will make a benefit determination and notify a claimant within a reasonable period of time, but not later than the maximum time period shown below. A written or electronic notification of any adverse benefit determination must be provided.

Disability Benefits

Guardian will provide a benefit determination not later than 45 days after the date of receipt of a claim. This period may be extended by up to 30 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a benefit determination may be extended for an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

If a claimant fails to provide all information needed to make a benefit determination, Guardian will notify the claimant of the specific information that is needed as soon as possible but no later than 45 days after receipt of the claim.

If Guardian extends the time period for making a benefit determination due to a claimant's failure to submit information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

Group Health Benefits

Urgent Care Claims. Guardian will make a benefit determination within 72 hours after receipt of an urgent care claim.

If a claimant fails to provide all information needed to make a benefit determination, Guardian will notify the claimant of the specific information that is needed as soon as possible but no later than 24 hours after receipt of the claim. The claimant will be given not less than 48 hours to provide the specified information.

Guardian will notify the claimant of the benefit determination as soon as possible but not later than the earlier of:

- the date the requested information is received; or
- the end of the period given to the claimant to provide the specified additional information.

The required notice may be provided to the claimant orally within the required time frame provided that a written or electronic notification is furnished to the claimant not later than 3 days after the oral notification.

Pre-Service Claims. Guardian will provide a benefit determination not later than 15 days after receipt of a pre-service claim. If a claimant fails to provide all information needed to make a benefit determination, Guardian will notify the claimant of the specific information that is needed as soon as possible but no later than 5 days after receipt of the claim. A notification of a failure to follow proper procedures for pre-service claims may be oral, unless a written notification is requested by the claimant.

The time period for providing a benefit determination may be extended by up to 15 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 15-day period.

If Guardian extends the time period for making a benefit determination due to a claimant's failure to submit information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

Post-Service Claims. Guardian will provide a benefit determination not later than 30 days after receipt of a post- service claim. If a claimant fails to provide all information needed to make a benefit determination, Guardian will notify the claimant of the specific information that is needed as soon as possible but no later than 30 days after receipt of the claim.

The time period for completing a benefit determination may be extended by up to 15 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 30-day period.

If Guardian extends the time period for making a benefit determination due to a claimant's failure to submit information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

Concurrent Care Decisions. A reduction or termination of an approved ongoing course of treatment (other than by plan amendment or termination) will be regarded as an adverse benefit determination. This is true whether the treatment is to be provided (a) over a period of time; (b) for a certain number of treatments; or (c) without a finite end date. Guardian will notify a claimant at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal.

In the case of a request by a claimant to extend an ongoing course of treatment involving urgent care, Guardian will make a benefit determination as soon as possible but no later than 24 hours after receipt of the claim.

B800.0077

All Options

Adverse Benefit Determination

If a claim is denied, Guardian will provide a notice that will set forth:

- the specific reason(s) for the adverse determination;
- reference to the specific plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to make the claim valid and an explanation of why such material or information is needed;
- a description of the plan's claim review procedures and the time limits applicable to such procedures, including a statement indicating that the claimant has the right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination;
- identification and description of any specific internal rule, guideline or protocol that was relied upon in making an adverse benefit determination, or a statement that a copy of such information will be provided to the claimant free of charge upon request;
- in the case of an adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request; and
- in the case of an urgent care adverse determination, a description of the expedited review process.

Appeal of Adverse Benefit Determinations

If a claim is wholly or partially denied, the claimant will have up to 180 days to make an appeal.

A request for an appeal of an adverse benefit determination involving an urgent care claim may be submitted orally or in writing. Necessary information and communication regarding an urgent care claim may be sent to Guardian by telephone, facsimile or similar expeditious manner.

Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

- the opportunity to submit written comments, documents, records and other information relating to the claim;
- the opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relating to the claim; and
- a review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will

- provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person's subordinate;
- in deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and
- ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person's subordinate.

Guardian will notify the claimant of its decision regarding review of an appeal as follows:

Disability Benefits

Guardian will notify the claimant of its decision not later than 45 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

Group Health Benefits

Urgent Care Claims.Guardian will notify the claimant of its decision as soon as possible but not later than 72 hours after receipt of the request for review of the adverse determination.

Pre-Service Claims. Guardian will notify the claimant of its decision not later than 30 days after receipt of the request for review of the adverse determination.

Post-Service Claims. Guardian will notify the claimant of its decision not later than 60 days after receipt of the request for review of the adverse determination.

Alternative Dispute Options

The claimant and the plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S Department of Labor Office and the State insurance regulatory agency.

B800.0078

Termination of This Group Plan

Your *employer* may terminate this group *plan* at any time by giving us 31 days advance written notice. This *plan* will also end if your *employer* fails to pay a premium due by the end of this grace period.

We may have the option to terminate this *plan* if the number of people insured falls below a certain level.

When this *plan* ends, you may be eligible to continue your insurance coverage. Your rights upon termination of the *plan* are explained in this booklet.

B800.0086

Life And Accidental Death And Dismemberment Insurance Claims Procedure

Claim forms and instructions for filing claims may be obtained from the Plan Administrator.

Guardian is the Claims Fiduciary with discretionary authority to determine eligibility for benefits and to construe the terms of the *plan* with respect to claims.

In addition to the basic claim procedure explained in your certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of the Employee Retirement Income Security Act of 1974 ("ERISA"):

(a) If a claim is wholly or partially denied, the claimant will be notified of the decision within 90 days after Guardian received the claim.

(b) If special circumstances require an extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which The Guardian expects to render the final decision.

(c) If a claim is denied, Guardian will provide a notice that will set forth:

  (1) the specific reason(s) the claim was denied;

  (2) specific references to the pertinent *plan* provision on which the denial is based;

  (3) a description of any additional material or information needed to make the claim valid, and an explanation of why the material or information is needed;

  (4) an explanation of the *plan's* claim review procedure.

A claimant must file a request for review of a denied claim within 60 days after receipt of written notification of denial of a claim.

(d) Guardian will notify the claimant of its decision within 60 days of receipt of the request for review. If special circumstances require an extension of time for processing, The Guardian will render a decision as soon as possible, but no later than 120 days after receiving the request. The Guardian will notify the claimant about the extension.

The claims procedures applicable to disability benefits under this plan apply to your application for an extension of life insurance benefits due to total disability under an Extended Life Benefit under this plan.

B800.0098

Termination of This Group Plan

Your *employer* may terminate this group *plan* at any time by giving us 31 days advance written notice. This *plan* will also end if your *employer* fails to pay a premium due by the end of this grace period.

We may have the option to terminate this *plan* if the number of people insured falls below a certain level.

When this *plan* ends, you may be eligible to continue or convert your insurance coverage. Your rights upon termination of the *plan* are explained in this booklet.

B800.0007

SECTION II: Managed Dental Care of California Dental Plan

This part of your booklet is your Managed Dental Care of California dental care plan. This part does not include any insurance that is being underwritten by Guardian.

None of the following provisions apply to any of your other insurance coverages.

B850.1557

This Booklet Includes All Managed Dental Care Benefits For Which You Are Eligible.

You are covered for any benefits provided to you by the policyholder at no cost.

But if you are required to pay all or part of the cost of insurance you will only be covered for those benefits you elected in a manner and mode acceptable to your Dental HMO such as an enrollment form and for which premium has been received.

"Please Read This Document Carefully".

B850.1499

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

Managed Dental Care of California
21820 Burbank Boulevard, Suite 200 or
Woodland Hills, California 91367
1-800-273-3330

We, MDC, certify that the *employee* named below is entitled to the benefits provided by MDC described in this form, provided the eligibility and effective date requirements of the *plan* are satisfied.

Group Policy No.	Form No.	Effective Date
Issued To		

"This Evidence of Coverage and Disclosure Form constitutes only a summary of the Health *plan.* The dental care *plan* contract must be consulted to determine the exact terms and conditions of coverage." A specimen copy of the *plan* contract will be furnished upon request. The Health Plan Benefits and Coverage Matrix is attached. The applicant has a right to view the Evidence of Coverage prior to enrollment. The Evidence of Coverage discloses the terms and conditions of coverage. What we cover is based on all the terms of this *plan.* Read this booklet carefully and completely for specific benefit levels, payment rates, payment limits, and copayments. Individuals with special health care needs should read carefully those sections that apply to them. You may call the MDC Member Service Department at 1-800-273-3330 if you have any questions after reading this booklet, or contact the *plan* at the *plan's* principal address listed above.

President

GENERAL PROVISIONS

Public Policy Committee

MDC maintains a Public Policy Committee composed of at least 3 Members, one Participating Dentist and one member of MDC's Board of Directors. Members may call MDC for more information about the Committee. MDC communicates material changes affecting public policy to members in periodic newsletters.

Confidentiality

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

You may contact our Member Services Department by telephone, 800-273-3330, or by mail to P.O. Box 4391, Woodland Hills, CA 91367 to request a copy of the plan's Confidentiality Statement. The Confidentiality Statement describes how MDC maintains the confidentiality of dental information obtained by and in the possession of MDC.

Option B

MEMBER ELIGIBILITY AND TERMINATION PROVISIONS

Enrollment Procedures

You and your Dependents may enroll for dental coverage by: (a) filling out and signing the appropriate enrollment form and any additional material required by your Employer; and (b) returning the enrollment material to your Employer. After your enrollment material has been received by MDC, You or your Dependents need only contact the selected and assigned Primary Care Dentist's office to obtain services.

MDC will issue You and each of your Dependents, either directly or through your Employer's representative, an MDC ID card. The ID card will show the Member's name and the name, address and telephone number of the selected and assigned Primary Care Dentist.

In the event dental coverage is provided for a dependent pursuant to a court or administrative order, a non-covered custodial parent (or guardian) will be provided a copy of the dependent's Evidence of Coverage and Disclosure Form and an ID card if requested by telephone or in writing. Upon receipt of appropriate notification, the Plan will notify the non-covered custodial parent or guardian if the dependent's coverage is altered or terminated.

In the event an eligible employee is required by a court or administrative order to provide dental coverage for a dependent, the dependent, who is otherwise eligible, will be permitted to enroll without regard to enrollment period restrictions.

If the enrolled employee fails to obtain coverage for the dependent, the dependent may be enrolled upon presentation of the court order, or request of the District Attorney, the other parent or guardian, or the Medi-Cal program.

The Plan shall not disenroll or eliminate coverage of the Dependent unless either of the following applies:

1. the Employer terminates coverage for all Employees.

2. the Plan is provided with satisfactory written evidence that either of the following apply:

   (a) court order or administrative order is no longer in effect or is terminated pursuant to Section 3770.

   (b) the dependent is or will be enrolled in comparable dental coverage that will take effect not later than the effective date of the dependent's disenrollment.

Eligible Dependents

Eligible Dependents are (1) your spouse, (2) your or your spouse's Dependent Child who is less than 26 years of age. The term Dependent Child as us this Plan will include any stepchild, newborn child between birth and age 36 months, legally adopted child, child for whom you are court appointed legal guardian, or proposed adoptive child, during any waiting period prior to the formal adoption if the child is part of your household and is primarily dependent on you for support and maintenance. The term also includes any child for whom a court-ordered decree requires you to provide dependent coverage; (3) a mentally retarded or physically handicapped Dependent Child who has reached the upper age limit of a Dependent Child, is not capable of self-sustaining work, and depends primarily on you for support and maintenance; (4) an Employee's domestic partner, who may be treated as a spouse under this Plan, subject to the conditions below:

An employee's domestic partner will be eligible for dental coverage under this Plan. "Domestic Partner" means an adult who has chosen to share his or her life with the employee in an intimate and committed relationship of mutual caring. Coverage will be provided subject to all of the terms of this Plan and to the following limitations:

To qualify for such coverage, both the employee and his or her domestic partner must:

- be 18 years of age or older;
- be unmarried, and not a member of another domestic partnership;
- have a common residence;
- agree to be jointly responsible for each other's basic living expenses incurred during the domestic partnership;
- not be related by blood in a way that would prevent them from being married to each other in the state of California;
- be capable of consenting to the domestic partnership;
- file a Declaration of Domestic Partnership with the Secretary of State of the state of California; and
- not have previously filed a Declaration of Domestic Partnership that has not been terminated; and
- be (a) members of the same sex, or (b) opposite sexes and one or both are eligible for Social Security benefits and over the age of 62.

Before coverage may become effective, the employee must submit to us, a copy of a valid Declaration of Domestic Partnership attesting to the relationship.

The domestic partner's dependent children will be eligible for coverage under this Plan on the same basis as if the children were the employee's dependent children.

Coverage for the domestic partner and his or her dependent children ends when the domestic partner no longer meets the qualifications of a domestic partner as described above. Upon termination of a domestic partnership, a "Notice of Termination of Domestic Partnership" must be completed and filed with the Secretary of State and the employer. A new Declaration of Domestic Partnership may not be filed with the Secretary of State until at least 6 months after the filing of a Notice of Termination of Domestic Partnership.

The domestic partner and his or her children will not be eligible for continuation of dental coverage as explained under the "Federal Continuation Rights" section of this Plan.

Eligibility

The determination of who is eligible to participate and who is actually participating in the plan shall be determined by your Employer and the group contract.

Any disputes or inquiries regarding eligibility, renewal, reinstatement and the like should be directed to your Employer or MDC as appropriate. MDC will not discriminate against any member based upon age, race, religion, national origin, sex, or sexual orientation.

Changes in Member Status

If a Member is terminated or is no longer employed: (a) he or she will continue to be eligible to receive services; and (b) MDC will be entitled to its monthly premium for the Member until such time that: (i) MDC is notified in writing of the Member's termination; and (ii) the Member is removed from the eligibility listing specified above.

SHOULD MDC BE NOTIFIED OF A MEMBER'S TERMINATION AFTER THE 20TH DAY OF THE MONTH FOLLOWING THE MONTH OF TERMINATION, MDC WILL RETAIN OR MUST BE PAID THE PREMIUM FOR THE MONTH IN WHICH THE MEMBER'S TERMINATION WAS REPORTED.

When Your Coverage Starts

Your coverage starts on the date shown on the face page of this *plan* if you are enrolled when the *plan* starts. If *you* are not enrolled on this date, your coverage will start on: (a) the first day of the month following the date enrollment materials are received by MDC; or (b) the first day of the month after the end of any waiting period your *employer* may require.

When Your Dependent Coverage Starts

Except as stated below, your *dependents* will be eligible for coverage on the later of (a) the day *you* are eligible for coverage; or (b) the first day of the month following the date on which *you* acquire such *dependent.* If your *dependent* is a newborn child, his or her coverage begins on the date of birth. If your *dependent* is: (a) an adopted child; (b) a stepchild; or (c) a foster child, coverage begins on the date of placement in your home. If a newborn child, adopted child or foster child becomes covered under this *plan, you* must complete enrollment materials for such child within 30 days of his or her effective date of coverage. Coverage does not terminate if enrollment materials are not received within 30 days.

Premium

Your Employer is responsible for paying MDC the monthly premium for your coverage. This amount, along with any portion you must pay, is shown in your enrollment kit.

Benefits, Limitations and Exclusions

A complete list of covered services, limitations and exclusions are included in the benefits section of this booklet. This is an essential part of this document. Many services are provided at no charge to you, while some procedures have a patient charge. Services specifically excluded from this coverage are listed in the section titled Exclusions and Limitations. Please read this section carefully. Dental services performed by a non-participating Dentist are not covered, except under certain emergency situations as explained under the section titled Emergency Care.

Renewal

MDC has contracted with your employer to provide services for a specific time period as specified in the group contract. You are covered under the plan for that period. Upon renewal of the group contract, it is possible the plan may be amended. Your employer will notify you of any benefit changes made at renewal.

Termination of Benefits

Subject to any continuation of coverage which may be available to you or your Dependents, coverage under this Plan ends when your Employer's coverage terminates. Your and your Dependents' coverage ends on the first to occur of:

Member Eligibility Reasons

(1) the end of the month in which a Member is no longer eligible for coverage under this Plan.

(2) the end of the month in which your Dependent is no longer a Dependent as defined in this Plan.

(3) the date on which you or your Dependent no longer reside or work in the Service Area.

A Member may be terminated at the end of the month following a period of at least fifteen (15) days from the date of notification of termination mailed by the Plan to the Member's address of record with the Plan. See Individual Continuation of Benefits, below.

Member Cancellation Reasons

(4) Immediately, as of date of notification, if a Member has knowingly given false information in writing on an enrollment form or has misused his or her ID card or other documents provided to obtain benefits available under this Plan.

Member will be terminated immediately upon notification of termination mailed by the Plan to the Member's address of record with the Plan.

(5) If the Member threatens the safety of Plan Employees, Dentists, Members, or other patients, or the Member's repeated behavior has substantially impaired the Plan's ability to furnish or arrange services for the Member or other Members, or substantially impaired a dentist's ability to provide services to other patients. Member will be terminated immediately upon notification of termination mailed by the Plan to the Member's address of record with the Plan.

A Member may be terminated at the end of the month following a period of at least fifteen (15) days from the date of notification of termination mailed by the Plan to the Member's address of record with the Plan.

MDC will: (a) make a reasonable effort to resolve the problem presented by the Member, including the use or attempted use of Member grievance procedures; (b) ascertain, to the extent possible, that the Member's behavior is not related to the use of medical services or mental illness; and (c) document the problems, efforts and medical conditions on which the problem is based.

Pursuant to Section 1365(b) of the Knox Keene Act, any Member who alleges his or her enrollment has been cancelled or not renewed because of his or her health status or requirement for services may request review by the California Department of Managed Health Care.

Group Cancellation Reasons

(6) The end of the month during which your Employer receives written notice from you requesting termination of coverage for you or your Dependents, or on such later date as you may request by the notice.

(7) A Member may also be terminated for Employer's nonpayment of premiums.

Nonpayment of Premiums

Member's coverage will be terminated for nonpayment of premiums. This will not occur until at least 15 days have passed following Plan's mailing of a notice of cancellation to Employer. This is not applicable to a loss of eligibility for Medi-Cal Benefits. The effect of nonpayment of premium will result in the Member being financially responsible for the cost of services rendered after termination of benefits. However, ongoing services initiated prior to Member's termination of coverage, including inlays, onlays, crowns, fixed bridges, orthodontic or root canal treatment shall be completed by the member's PCD at the applicable Copayment.

Notice of Cancellation

MDC will notify Employer in writing of the cancellation of the Group Contract. The group may be terminated at the end of the month following a period of at least (15) days from the date of notification of termination mailed to the Employer's address of record with the Plan. A notice of termination will be sent to the Employer following the (15) day notification period. Employer is required to mail Employees a legible, true copy of any notice of cancellation of the Group Contract which may be received from the Plan and must provide MDC with proof of the mailing and date of mailing, within 72 hours of receipt of Notice of Cancellation. The notice will include information regarding the conversion rights of Members covered under the Plan Contract. Plan will accept a copy of the notice as proof.

If the Group does not avoid cancellation of the Group Contract within the required 15 days, or if the Group Contract is cancelled for nonpayment during a contract year, the Group may need to reapply for coverage with a new application, for which the Plan may impose different premiums. The effect of nonpayment of premium will result in the Member being financially responsible for the cost of services rendered after termination of benefits. However, ongoing services initiated prior to Member's termination of coverage, including inlays, onlays, crowns, fixed bridges, dentures, orthodontic or root canal treatment shall be completed by the Member's PCD at the applicable Copayment.

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YOUR CONTINUATION RIGHTS

You and *your* dependents may be eligible to retain coverage under this *plan* during any Continuation of Coverage period or election period, necessary for your *employer's* compliance with requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) and any regulations adopted thereunder, or any similar state law requiring the Continuation of Benefits for *members,* provided the *employer* continues to certify the eligibility of the *member* and the monthly premiums for COBRA coverage for the *member* continue to be paid by or through your *employer* pursuant to this *plan.*

An Important Notice About Continuation Rights

The following "Federal Continuation Rights" section may not apply to your employer's plan. You must contact your employer to find out if: (a) your employer is subject to the "Federal Continuation Rights" section, and therefore; (b) the section applies to you.

Federal Continuation Rights

Important Notice

This notice contains important information about the right to continue group dental coverage. In addition to the continuation rights described below, other health coverage alternatives may be available through states' Health Insurance Marketplaces. Please read the information contained in this notice very carefully.

This section applies to dental benefits only. In this section, these coverages are referred to as "group dental benefits."

Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for dental benefits under this plan as: (a) an active, covered *employee;* (b) the spouse of an active, covered *employee;* or (c) the *dependent* of an active, covered *employee.* Any person who becomes covered under this *plan* during a continuation provided by this section is not a qualified continuee.

If Your Group Dental Benefits End

If your group dental benefits end due to termination of employment or reduction of work hours, *you* may elect to continue such benefits for up to 18 months if: (a) *you* were not terminated due to gross misconduct; (b) *you* are not covered for benefits from any other group plan at the time your group dental benefits under this plan would otherwise end; and (c) *you* are not entitled to Medicare.

The Continuation: (a) may cover *you* and any other qualified continuee; and (b) is subject to "When Continuation Ends."

Extra Continuation For Disabled Qualified Continuees

If a qualified continuee is determined to be disabled under Title XVI of the Social Security Act on the date his or her group dental benefits would otherwise end due to his or her termination of employment or reduction of work hours, he or she may elect to extend his or her 18 month continuation period explained above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give your *employer* written proof of Social Security's determination of his or her disability before the earlier of: (a) the end of the 18 month continuation period; and (b) 60 days after the date the qualified continuee is determined to be disabled. If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify your *employer* within 30 days of such determination, and continuation will end, as explained in "When Continuation Ends."

This extra 11 month continuation: (a) may be elected only by the disabled qualified continuee; and (b) is subject to "When Continuation Ends."

An additional 50% of the total premium charge also may be required from the qualified continuee by your *employer* during this extra 11 month continuation period.

If You Die While Insured

If *you* die while insured, any qualified continuee whose group dental benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to "When Continuation Ends."

If Your Marriage Ends

If your marriage ends due to legal divorce or legal separation, any qualified continuee whose group dental benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to "When Continuation Ends."

If a Dependent loses Eligibility

If a *dependent's* group dental benefits end due to his or her loss of dependent eligibility as defined in this *plan,* other than your coverage ending, he or she may elect to continue such benefits. But, such *dependent* must be a qualified continuee. The continuation can last for up to 36 months, subject to "When Continuation Ends."

Concurrent Continuations

If a *dependent* elects to continue his or her group dental benefits due to: (a) your termination of employment; or (b) your reduction of work hours, the *dependent* may elect to extend his or her 18 month continuation period up to 36 months, if during the 18 month continuation period, either: (a) the *dependent* becomes eligible for 36 months of group dental benefits due to any of the reasons stated above; or (b) *you* become entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started. And, the two continuation periods will be deemed to have run concurrently.

The Qualified Continuee's Responsibilities

A person eligible for continuation under this section must notify your *employer,* in writing, of: (a) your legal divorce or legal separation from your spouse; or (b) the loss of dependent eligibility, as defined in this *plan,* of a *dependent.*

Such notice must be given to your *employer* within 60 days of either of these events.

Your Employer's Responsibilities

Your *employer* must notify the qualified continuee, in writing, of: (a) his or her right to continue this *plan's* group dental benefits; (b) the monthly premium he or she must pay to continue such benefits; and (c) the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of: (a) the date a qualified continuee's group health benefits would otherwise end due to your death or your termination of employment or reduction of work hours; or (b) the date a qualified continuee notifies your *employer,* in writing, of your legal divorce or legal separation from your spouse, or the loss of dependent eligibility of a *dependent.*

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Your Employer's Liability

Your *employer* will be liable for the qualified continuee's continued group dental benefits to the same extent as, and in place of, MDC if: (a) your *employer* fails to remit a qualified continuee's timely premium payment to MDC on time, thereby causing the qualified continuee's continued group dental benefits to end; or (b) your *employer* fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation

To continue his or her group dental benefits, the qualified continuee must give your *employer* written notice that he or she elects to continue. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from your *employer* as described above. And the qualified continuee must pay his or her first month's premium in a timely manner.

The subsequent premiums must be paid to your *employer,* by the qualified continuee, in advance, at the times and in the manner specified by your *employer.* No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group dental benefits had the qualified continuee stayed enrolled in the group *plan* on a regular basis. It includes any amount that would have been paid by your *employer.* Except as explained in the "Extra Continuation for Disabled Qualified Continuees," your *employer* may also require an additional charge of 2% of the total premium charge.

If the qualified continuee: (a) fails to give your *employer* notice of his or her intent to continue; or (b) fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums

A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified due date.

When Continuation Ends

A qualified continuee's continued group dental benefits end on the first to occur of:

(a) with respect to continuation upon your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group dental benefits would otherwise end;

(b) with respect to a disabled qualified continuee who has elected an additional 11 months of continuation, the earlier of: (1) the end of the 29 month period which starts on the date the group dental benefits would otherwise end; or (2) the first day of the month which coincides with or next follows the date which is 30 days after the date on which final determination is made that a disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;

(c) with respect to continuation upon your death, your legal divorce or legal separation, or the end of a *dependent's* eligibility, the end of the 36 month period which starts on the date the group dental benefits would otherwise end;

(d) with respect to a *dependent* whose continuation is extended due to your entitlement to Medicare, the end of the 36 month period which starts on the date the group dental benefits would otherwise end;

(e) the date the *plan* ends;

(f) the end of the period for which the last premium payment is made;

(g) the date he or she becomes covered under any other group dental plan which contains no limitation or exclusion with respect to any pre-existing condition of the qualified continuee; or

(h) the date he or she becomes entitled to Medicare.

Option B

DENTAL EXPENSE COVERAGE

This *plan* will cover many of the dental expenses incurred by *you* and those of your *dependents* who are covered for dental benefits under this *plan.* MDC decides: (a) the requirements for benefits to be paid; and (b) what benefits are to be paid by this *plan. We* also interpret how this *plan* is to be administered. What *we* cover and the terms of coverage are explained below. All terms in italics are defined terms with special meanings. Their definitions are shown in the "Glossary" at the back of this booklet. Other terms are defined where they are used.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

MANAGED DENTALGUARD

MANAGED DENTAL CARE'S DENTAL COVERAGE PROGRAM

Managed DentalGuard

This *plan* is designed to provide quality dental care while controlling the cost of such care. To do this, this *plan* requires *members* to seek dental care from *participating dentists* that belong to the Managed DentalGuard network (MDG network).

The MDG network is made up of *participating dentists* in a *member's* Service Area. A *" participating dentist"* is a *dentist* that has a Managed DentalGuard agreement in force with MDC.

When a *member* enrolls in this *plan,* he or she will get information about MDC's current *participating general dentists.* Each *member* must select from this list of *participating general dentists* a *primary care dentist* (PCD) who will be responsible for coordinating all of the *member's* dental care. After enrollment, a *member* will receive a MDC ID card. A *member* must present this ID card when he or she goes to his or her *PCD.*

All dental services covered by this *plan* must be coordinated by the *PCD* whom *the member* selects and is assigned to upon enrolling in this *plan.* What *we* cover is based on all the terms of this *plan.* Read this *plan* carefully for specific benefit levels, exclusions and limitations and *patient charges.*

You can call the MDC Member Services Department if *you* have any questions after reading this booklet.

MDC has a written plan describing how this *plan* facilitates the continuity of care for new *members* receiving services from a *non-participating dentist* during a current episode of care for an acute condition. A *member* may request a copy of MDC's written plan which includes information on how he or she may request a review under this *plan.*

Choice of Dentists

A Member may select any available *participating general dentist* as his or her *PCD.* A request to change a *PCD* must be made to MDC at 1-800-273-3330. Any such change will be effective the first day of the month following approval. MDC may require up to 30 days to process and approve any such request. All fees and *patient charges* due to the *member's* current *PCD* must be paid in full prior to such a transfer.

MDC compensates its *participating general dentists* through a capitation agreement by which they are paid a fixed amount of money each month, based upon the number of members that select them as their *PCD.*

MDC may also make supplemental payments on a limited number of specific procedures, office visit payments and annual guarantee payments. These are the only forms of compensation the *participating general dentist* receives from MDC. The *dentists* also receive compensation from plan members who may pay an office visit charge for each office visit and a defined *patient charge* for specific dental services. The schedule of *patient charges* is shown in the Covered Dental Services and Patient Charge section of this booklet.

If a *member* wishes to know more about these issues, the *member* may request additional information from the health care service plan, the *member's dentist* or the *dentist's* medical group or independent practice association regarding this information.

You may wish to consult another *dentist* for a second opinion regarding services recommended or performed by your PCD or a *participating specialist* through an authorized referral. To have a second opinion consultation covered by MDC, *you* must call or write Member Services for prior authorization. MDC will only cover a second opinion consultation when the recommended services are otherwise covered under the *plan.*

A Member Services Representative will help *you* identify a *participating dentist* to perform the second opinion consultation. *You* may request a second opinion with a non-participating general *dentist* or specialist *dentist.* The Member Services Representative will arrange for any available records or radiographs and the necessary second opinion form to be sent to the consulting dentist.

You may appeal a denial for a second opinion to:

Managed Dental Care of California
Grievance Committee
21820 Burbank Boulevard, Suite 200
Woodland Hills CA 91367

The appeal will be reviewed through the *plan's* grievance process on the basis of the necessity of the treatment and/or specialty procedure being recommended. Appeals are reviewed on the basis of all available dental records and the input of the referring dentist or specialist. All appeals for the necessity of a second opinion are reviewed by a *dentist* having appropriate clinical background, as determined by MDC's Dental Director.

Right to Reassign Member: MDC reserves the right to reassign you to a different Participating Dentist if: (a) the Dentist you have chosen is no longer a Participating Dentist in the MDG network; or (b) MDC takes an administrative action which impacts a Dentist's participation in the network. If this becomes necessary, you will have the opportunity to choose another Participating Dentist. If a Member has a dental service in progress at the time of the reassignment, MDC will, at its option and subject to applicable law, either: (a) arrange for completion of the services by the original Dentist; or (b) make reasonable and appropriate arrangements for another Participating Dentist to complete the service.

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Additional Information

In the event that MDC fails to pay your PCD, you shall not be liable to the participating general dentist for any sums owed by the *plan.* In the event MDC fails to pay a Non-Participating Dentist, you may be liable to the Non-Participating Dentist for the cost of services rendered.

Relationship Between You and Participating Dentists and Institutions:

You understand that: (a) the operation and maintenance of the participating dental offices, facilities and equipment; and (b) the rendition of all dental services will be solely and exclusively under the control and supervision of a Participating Dentist. The Participating Dentist has all authority and control over: (a) the selection of staff; (b) supervision of personnel and operation of the professional practice; and/or (c) the rendering of any particular service or treatment

MDC will undertake to see that the services provided to Members by Participating Dentists will be performed in accordance with professional standards prevailing in the county in which each Participating Dentist practices.

Specialty Referrals

A Member's PCD is responsible for providing all covered services. But, certain services may be eligible for referral to a Participating Specialist. MDC will pay for covered services for specialty care, less any applicable Patient Charges, when such specialty services are provided in accordance with the specialty referral process described below.

MDC compensates its Participating Specialists the difference between their contracted fee and the Patient Charge shown in the Covered Dental Services and Patient Charges section. This is the only form of compensation that Participating Specialists receive from MDC.

ALL SPECIALTY REFERRAL SERVICES MUST BE (A) PRE-AUTHORIZED BY MDC; AND (B) COORDINATED BY A MEMBER'S PCD. ANY MEMBER WHO ELECTS SPECIALIST CARE WITHOUT PRIOR REFERRAL BY HIS OR HER PCD AND APPROVAL BY MDC IS RESPONSIBLE FOR ALL CHARGES INCURRED.

EMERGENCY REFERRALS AUTHORIZED BY TELEPHONE MUST FOLLOW REFERRAL GUIDELINES TO BE COVERED UNDER THE *PLAN* OR RETROSPECTIVELY IT MAY BE DETERMINED THAT SERVICES RENDERED MAY BE THE RESPONSIBILITY OF THE REFERRING DENTIST AND/OR *YOU. YOU* ARE NOT HELD RESPONSIBLE IF THE REFERRING DENTIST DOES NOT FOLLOW *PLAN* GUIDELINES.

Utilization Review

In order for specialty services to be covered by this *plan,* the specialty referral process stated below must be followed:

1. A *member's PCD* must coordinate all dental care.
2. When the care of a *participating specialist* is required, the *PCD* must contact MDC and request authorization.
3. If the *PCD's* request for specialist referral is approved, MDC will notify *you.* He or she will be instructed to contact the *participating specialist* to schedule an appointment.

4. If the *PCD's* request for specialist referral is denied, the *PCD* and the *member* will be notified of the reason for the denial. If the service in question: (a) is a covered service; and (b) no exclusions or limitations apply, the *PCD* may be asked to perform the service directly, or to provide additional information.

5. If a request for specialist referral is denied and the *member* wishes to submit additional information or documentation to be considered in the evaluation of the request, he or she may submit an appeal of the determination. The appeal of a denied request for authorization will follow the grievance process.

6. A *member* who receives authorized specialty services must pay for all applicable *patient charges* associated with the services provided.

   When specialty dental care is authorized by MDC, a *member* will be referred to a *participating specialist* for treatment. The MDG network includes *participating specialists* in: (a) oral surgery; (b) periodontics; (c) endodontics; (d) pediatric dentistry; and (e) orthodontics, located in the Member's Service Area. If there is no *participating specialist* in the *member's service area,* or if the specialist is not readily available and accessible as defined by MDC's Access Standards (Member Services may be contacted at 1-800-273-3330 for Plan Access and Availability Standards), MDC will refer *you* to a non-participating specialist of our choice. For those services approved in writing with a non-participating specialist, *you* will only be responsible for the applicable *patient charge* that would apply if the services were rendered by a contracted specialist. If *you* receive a bill from a non-participating specialist for charges other than the applicable *patient charge, you* will forward the bill to the *plan* for appropriate follow up. The bill should be sent to the attention of the Specialty Referral Department, P.O. Box 4391, Woodland Hills CA 91367, or 21820 Burbank Boulevard, Suite 200, Woodland Hills CA 91367. In no event will MDC pay for dental care provided to a *member* by a specialist not pre-authorized by MDC to provide such services.

7. A *member,* member's designee and/or *dentist* whose *specialty referral* is denied as the service is not consistent with our clinical referral guidelines or is not necessary will receive written notification with a clear, concise explanation of the reasons for MDC's decision, a description of the screening criteria used, and the clinical reasons for the decision. The notification shall also include information as to how the *member* or member's designee may file an appeal or a grievance.

8. A *member,* member's designee and/or members of the public may request a copy of MDC's Specialty Referral Guidelines and/or Utilization Review and Utilization Review Appeals Processes. These are MDC's written policies and procedures that have established the processes by which the *plan* prospectively, retrospectively or concurrently reviews and approves, modifies, delays, denies, in whole or in part on medical necessity requests by dentists for plan enrollees. A copy may be obtained by contacting the Member Services Department by telephone at 800-273-3330 or by mail at P.O. Box 4391, Woodland Hills CA 91367.

Facilities

MDC's *PCD* offices are open during normal business hours and some offices are open limited Saturday hours. Please remember, if you cannot keep your scheduled appointment, you must notify your *PCD* at least 24 hours in advance or *you* will be responsible for the broken appointment fee listed in the Covered Dental Services and Patient Charges section of this booklet.

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Emergency Dental Services

The MDG network also provides for *emergency dental services* 24 hours a day, 7 days a week, to all *members.* a *member* should contact his or her selected *PCD,* who will arrange for such care. If a *member* is not able to reach his or her *PCD* in an emergency during normal business hours, he or she must call MDC's Member Services Department for instructions. If a *member* is not able to reach his or her *PCD* in an emergency after normal business hours, the *member* may seek *emergency dental services* from any *dentist.* MDC will reimburse the *member* for the cost of the *emergency dental services,* less any *patient charge* which may apply.

Out-of-Area Emergency Dental Services

If a *member* is more than 50 miles from his or her *PCD's* office, and *emergency dental services* are required, he or she should seek care from a *dentist.* then he or she must file a claim within 30 days. He or she must present an acceptable detailed statement from the treating *dentist.* the statement must list all services provided. MDC will reimburse the *member* within 30 days for any covered *emergency dental services* up to $50.00 per incident.

Continuity of Care - Terminated Dentist

Member may request for the continuation of covered services to be rendered by a terminated *participating dentist* when *member* is undergoing treatment from a terminated dentist for an acute condition or serious chronic condition, performance of surgery or other procedure authorized by MDC as part of a documented course of treatment that is to occur within 180 days of the contract termination date for current members or 180 days from the effective date for newly covered members. This includes completion of covered services for newborn children between birth and age 36 months for 12 months from the termination date of the Participating Dentist's Agreement or 12 months from the effective date of coverage for newly covered members. This provision does not apply to *participating dentists* who voluntarily leave the *plan. Member* must make the request in writing and send to:

Managed Dental Care of California
Quality Management Department
21820 Burbank Boulevard, Suite 200
Woodland Hills CA 91367

Or contact MDC's Member Services Department at 1-800-273-3330 during normal business hours. The terminating *dentist* must accept the contracted rate for that member's treatment and agree not to seek payment from the *member* for any amounts for which the *member* would not be responsible if the *dentist* were still in the network. The approval of the request to continue member's treatment will be at the discretion of the Dental Director. MDC is not required to provide benefits that are not otherwise covered under the terms and conditions of the group contract. In the event the terminating *dentist* or *member* wishes to appeal an adverse decision, the Peer Review Committee will review the request and make the final determination.

This provision will not apply to any terminated dentist for reasons relating to a disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Professional Code, or fraud or other criminal activity.

Continuity of Care - Non-Participating Dentist

Member, including a newly covered member, may request for the continuation of covered services to be rendered by the *non-participating dentist* when *member* is undergoing treatment from the *non-participating dentist* for an acute condition, serious chronic condition, performance of surgery, or other procedure authorized by MDC as part of a documented course of treatment that is to occur within 180 days. This includes completion of covered services for newborn children between birth and age 36 months for 12 months from the termination date of the Non-Participating Dentist's Agreement or 12 months from the effective date of coverage for newly covered Members. Member must make the request in writing and send to:

Managed Dental Care of California
Quality Management Department
21820 Burbank Boulevard, Suite 200
Woodland Hills CA 91367

Or contact MDC's Member Services Department at 1-800-273-3330 during normal business hours. MDC may obtain copies of the *member's* dental records from the *member's dentist* in order to evaluate the request. The Dental Director (or his/her designee) will determine if the *member* is eligible for continuation of care under this policy and the California Knox-Keene Act. The Dental Director's decision shall be consistent with professionally recognized standards of practice. The Dental Director shall consider:

1. Whether one of the circumstances described above exists;
2. Whether the requested services are covered by *plan;* and
3. The potential clinical effect that a change of dentist would have on the Member's treatment.

MDC requires the terminated or non-participating dentist to agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracted dentists, including, but not limited to, credentialing, hospital privileging, utilization review, peer review and quality assurance requirements. MDC is not required to continue the services a *dentist* is providing to a *member* if the *dentist* does not agree to comply or does not comply with these contractual terms and conditions.

Unless MDC and *dentist* agree otherwise, the services rendered pursuant to this policy shall be compensated at rates and methods of payment similar to those used by MDC for currently contracted dentists providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the non-participating dentist. MDC is not required to continue the services a dentist is providing to a Member if the dentist does not accept the payment rates provided for in this paragraph.

The amount of, and the requirement for payment of copayments during the period of completion of covered services with a terminated dentist or a non-participating dentist are the same as would be paid by the *member* if receiving care from a dentist currently contracted with MDC.

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MANAGED DENTAL CARE GRIEVANCE PROCESS

Member grievances are to be submitted to MDC's Quality of Care Liaison or Designee ("QCL") who processes all grievances. The QCL may be contacted at 800-273-3330 between the hours of 8:00 a.m. and 5:00 p.m. Pacific Time or by mail to P.O. Box 4391, Woodland Hills, CA 91367, or 21820 Burbank Boulevard, Suite 200, Woodland Hills, CA 91367. Grievances may also be submitted on the Plan's website at www.manageddentalcare.net.

The grievance process is designed to address Member concerns quickly and satisfactorily. It is generally recognized that grievances may be classified into two categories:

Administrative Services financial, accounting, procedural matters, coverage information such as effective dates, explanations of Contract and Evidence of Coverage, claims, benefits and coverage, or benefit terms and definitions.

Health Services quality of care, access, availability, standards of care, appeal of denied second opinion requests, Utilization Review Appeals, professional and ethical considerations.

A Grievance means any dissatisfaction expressed by a Member, orally or in writing, regarding the plan's operation, including but not limited to, plan administration, denial of access to a specialty referral as services are covered at the general dentist office, a determination that a procedure is not covered under the contract, an appeal of a denied second opinion request, the denial, reduction, or termination of a service, the way a service is provided, or disenrollment decisions. A grievance related to the denial of specialty care services for lack of medical necessity will be handled by the grievance process. The Plan will not treat inquiries as grievances, but if the Plan cannot distinguish between an inquiry and a grievance, they shall be considered grievances.

A grievance and a complaint are one and the same.

Coverage dispute means that the Member is not provided a covered service as a Plan benefit.

In order to be responsive to Member problems and concerns about coverage provided by MDC, the following grievance procedures have been established:

1. Questions or concerns may be directed to MDC either by telephone or by mail by the Member or Member's Designee ("Member"). When Member inquiries are received by telephone, the Member Services Representative documents the call and works with the Member to resolve the issue. If the issue is an inquiry or complaint and is not a coverage dispute, a disputed dental care service involving medical necessity or experimental or investigational treatment, and that is resolved by the next business day following receipt, it may be handled by the Member Services Department. All other issues that are grievances will be documented on a Grievance Form by the Member Services Representative on behalf of the Member and the Grievance Form will be forwarded to the Quality of Care Liaison or Designee ("QCL"). The Member may be sent a Grievance Form (Exhibit 2) to complete, if requested.

   A Member may visit MDC's website at www.manageddentalcare.net to submit a grievance. From the homepage, the Member must select the "Grievance Form" button. The Member will then be able to provide selected information and describe the grievance in detail. Following the completion of the Grievance Form, the Member is given the option to review the completed form prior to submission to MDC. The Member must then select the "Submit" button to send the grievance to MDC. All grievances submitted via MDC's website will be forwarded to the QCL or Designee.

   When a Member who files a grievance or wants to file a grievance has a language barrier, cultural need or disability that requires special assistance, the Member Services Department will work the QCL and provide accommodation, according to Plan guidelines.

2. Assistance in filing grievances shall be provided at each dental office as well as by the Plan. Each dental office has a grievance form and a description of the grievance process readily available and will provide the form promptly upon request. The dental office will submit the grievance form to MDC at the Member's request.

3. Members may file a grievance up to 180 days following any incident or action that is the subject of the dissatisfaction.

4. No later than five(5) calendar days after receipt of the grievance, an acknowledgement letter (exhibit 3) is sent to the Member indicating the date the grievance was received, the name and telephone number of the QCL, that a review is taking place and the grievance will be responded to within 30 days from the date of the Plan's receipt of the grievance in a resolution letter.

5. Under the supervision of the QCL, supporting documentation is collected on the issue. The dental office may be requested to provide additional information, such as copies of all relevant dental records and radiographs, and statements of the dentist or office personnel. MDC may arrange a second opinion, if appropriate.

6. Upon receipt of complete documentation, a resolution is determined based upon objective evaluation. A resolution letter will be sent to the Member within 30 days from the date of the Plan's receipt of the grievance. Quality of care issues or potential quality of care issues are resolved under the supervision of the Dental Director or designee (Dental Director). Issues of a complex nature and/or quality of care issues, at the discretion of the Dental Director, may be presented to the Grievance Committee or Peer Review Committee for review and resolution. The Dental Director reviews all quality of care or potential quality of care grievances at least biweekly and reviews and approves all letters of resolution that are sent to Members. The Dental Director will indicate his or her review of available documentation by initialing a copy of the resolution letter.

   The resolution letter to the Member will detail in a clear, concise manner the reasons for the Plan's response. For grievances involving the delay, denial or modification of health care services, the response letter shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If the Plan, or one of its clinical reviewers, issues a determination delaying, denying or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the Member, the letter shall clearly specify the provisions in the contract that exclude that coverage.

7. Within thirty (30) days following receipt of a resolution letter, a Member, or Member's designee, may also request voluntary mediation with the Plan prior to exercising the right to submit a grievance to the Department of Managed Health Care. Additional time may be requested due to a member's extraordinary circumstance. The use of mediation services shall not preclude the right to submit a grievance to the Department of Managed Health Care upon completion of mediation. In order to initiate mediation, the Member or designee and the Plan shall voluntarily agree to mediation. Expenses for mediation shall be born equally by both sides. Members only need to participate in the voluntary mediation process for thirty (30) calendar days prior to submitting a complaint to the Department of Managed Health Care. The Department of Managed Health Care shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process authorized by this paragraph.

   The use of voluntary mediation services shall not preclude the right to submit a grievance to the Department of Managed Health Care upon completion of mediation.

   Following the use of the Voluntary Mediation process, the Member and MDC each have the right to use the legal system or arbitration for any claim involving the professional treatment performed by a dentist.

8. A grievance may be submitted to the Department of Managed Health Care for review and resolution prior to any arbitration.

9. Members shall not be required to complete the grievance process, or participate in the process for at least thirty (30) days before submitting a complaint to the Department of Managed Health Care in any case determined by the Department of Managed Health Care to be a case involving an imminent and serious threat to the health of the patient, including but not limited to severe pain, the potential loss of life, limb or major bodily function, or in any other case where the Department of Managed Health Care determines that an earlier review is warranted.

10. The plan shall keep all copies of grievances, and the responses to grievances, for a period of five years.

11. The Vice President Operations and Finance who is an officer of the Plan, or designee, has primary responsibility for the Plan's grievance system.

12. A written record of office specific and aggregate tabulated grievances will be maintained for each grievance received by the Plan and that record will be reviewed quarterly by the Dental Director, the Quality Assurance Committee, the Public Policy Committee and the Board of Directors.

13. MDC asserts that there is no discrimination against an enrollee or subscriber (including cancellation of the contract) solely on the grounds that the enrollee filed a complaint.

Grievances Requiring Expedited Review

The Plan will review grievances on an expedited basis when the grievances involve an imminent and serious threat to the health of the member, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. They may also include, but not be limited to procedures administered in a hospital, dentist's office, dental clinic, or other comparable facility, to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, acute infection, fever, swelling or to prevent the imminent loss of teeth that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed and which are covered under the Plan.

When the Plan has notice of a grievance requiring expedited review, the grievance process requires the Plan to immediately inform members in writing of their right to notify the Department of Managed Health Care of the grievance. The Plan also will provide members and the Department of Managed Health Care with a written statement on the disposition or pending status of the grievance no later than three days from receipt of the grievance.

The following grievance disclosure will be on all member correspondence:

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-273-3330** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll free telephone number **1-888-HMO-2219** and a TDD line **1-877-688-9891** for the hearing and speech impaired. The department's internet web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

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Option B

Covered Dental Services And Patient Charges - Plan 90 M

The services covered by this *plan* are named in this list. If a procedure is not on this list, it is not covered. All services must be provided by the *PCD* selected by the *member.* The *member* must pay the listed *patient charge.* The benefits we provide are subject to all of the terms of this *plan,* including the Limitations on Benefits for Specific Covered Services, Additional Conditions on Covered Services, and Exclusions.

These *patient charges* are only valid for covered services rendered by *participating dentists* in the state of California.

MDG Codes+	Description of Service	Patient Charge
	Appointments and Diagnostic Services	
0101	Office Visit - during regular hours - participating general dentist only	$5.00
0102	Broken Appointment (without 24 hours' notice)	$25.00
0120, 0140, 0150	Oral evaluation	No Charge
0460	Pulp vitality tests	No Charge
0470	Diagnostic casts	No Charge
9310	Consultation (by dentist other than practitioner providing treatment)	No Charge
9430	Office visit for observation - regular hours - no other service performed	No Charge
9440	Emergency office visit - after regularly scheduled office hours	$50.00
	Radiographs	
0210	Intraoral - complete series (including bitewings)	No Charge
0220, 0230, 0240	Intraoral - periapical or occlusal - single film	No Charge
0270, 0272, 0274	Bitewings	No Charge
0330	Panoramic film	No Charge
	Preventive Services & Space Maintenance	
1110, 1120	Prophylaxis	No Charge
1201, 1203	Topical application of fluoride (may include prophylaxis) - child	No Charge
1310	Nutritional counseling for control of dental diseases	No Charge
1330	Oral hygiene instruction	No Charge
1351	Sealant - per tooth	No Charge
1510	Space maintainer - fixed - unilateral	No Charge
1515	Space maintainer - fixed - bilateral	No Charge
1550	Recementation of space maintainer	No Charge
	Restorative	
2110	Amalgam - one surface - primary	No Charge
2120	Amalgam - two surfaces - primary	No Charge
2130	Amalgam - three surfaces - primary	No Charge
2131	Amalgam - four or more surfaces - primary	No Charge
2140	Amalgam - one surface - permanent	No Charge
2150	Amalgam - two surfaces - permanent	No Charge

2160	Amalgam - three surfaces - permanent	No Charge
2161	Amalgam - four or more surfaces - permanent	No Charge
2210	Silicate cement - per restoration	No Charge
2330	Resin/composite - one surface, anterior	No Charge
2331	Resin/composite - two surfaces, anterior	No Charge
2332	Resin/composite - three surfaces, anterior	No Charge
2335	Resin/composite - four or more surfaces or incisal angle, anterior	No Charge
2336	Composite resin crown, anterior - primary	No Charge
2380	Resin/composite - one surface, posterior - primary	No Charge
2381	Resin/composite - two surfaces, posterior - primary	No Charge
2382	Resin/composite - three or more surfaces, posterior - primary	No Charge
2385	Resin/composite - one surface, posterior - permanent	No Charge
2386	Resin/composite - two surfaces, posterior - permanent	No Charge
2387	Resin/composite - three or more surfaces, posterior - permanent	No Charge

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Crown, Bridge & Other Cast Restorations

2510	Inlay - metallic - one surface*	$60.00
2520, 6520	Inlay - metallic - two surfaces*	$75.00
2530, 6530	Inlay - metallic - three or more surfaces*	$75.00
2543, 6543	Onlay - metallic - three surfaces*	$80.00
2544, 6544	Onlay - metallic - four or more surfaces*	$80.00
2702	Crown supporting existing partial denture - in addition to crown	$125.00
2703	Multiple crown and bridge unit treatment plan - per unit	$125.00
2740	Crown - porcelain/ceramic substrate	$100.00
2750, 2751, 2752	Crown - porcelain fused to metal*	$95.00
2790, 2791, 2792	Crown - full cast metal*	$90.00
2810, 6780	Crown - 3/4 cast metallic*	$95.00
6210, 6211, 6212	Pontic - cast metal*	$90.00
6240, 6241, 6242	Pontic - porcelain fused to metal*	$95.00
6750, 6751, 6752	Crown - abutment - porcelain fused to metal*	$95.00
6790, 6791, 6792	Crown - abutment - full cast metal*	$90.00

Other Restorative Services

2910, 2920, 6930	Recementation inlay, crown, bridge	No Charge
2930, 2931	Prefabricated stainless steel crown	$10.00
2932	Prefabricated resin crown	$20.00
2940	Sedative filling	No Charge
2950, 6973	Core buildup, including any pins	$20.00
2951	Pin retention - per tooth, in addition to restoration	No Charge
2952, 6970	Cast post & core	$30.00
2954, 6972	Prefabricated post & core	$25.00
2960	Labial veneer (laminate) - chairside	$40.00

Endodontics

3110, 3120	Pulp cap	No Charge
3220	Therapeutic pulpotomy	No Charge
3310	Root canal - anterior	No Charge
3320	Root canal - bicuspid	No Charge

3330	Root canal - molar	$90.00
3346	Root canal - retreatment - anterior	No Charge
3347	Root canal - retreatment - bicuspid	No Charge
3348	Root canal - retreatment - molar	$95.00
3410	Apicoectomy/periradicular surgery - anterior	$55.00
3421	Apicoectomy/periradicular surgery - bicuspid - first root	$60.00
3425	Apicoectomy/periradicular surgery - molar - first root	$60.00
3426	Apicoectomy/periradicular surgery - each additional root	$25.00
3430	Retrograde filling - per root	$10.00

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Periodontics

4210	Gingivectomy or gingivoplasty - per quadrant	$35.00
4211	Gingivectomy or gingivoplasty - per tooth	$15.00
4240	Gingival flap procedure - including root planing - per quadrant	$65.00
4249	Clinical crown lengthening - hard tissue	$55.00
4260	Osseous surgery - including flap entry, closure - per quadrant - five to eight teeth	$95.00
4261	Osseous surgery - including flap entry, closure - per quadrant - one to four teeth	$60.00
4270	Pedicle soft tissue graft procedure	$65.00
4271	Free soft tissue graft procedure (including donor site surgery)	$70.00
4341	Periodontal scaling & root planing - per quadrant	No Charge
4355	Full mouth debridement to enable evaluation and diagnosis	No Charge
4910	Periodontal maintenance procedures (following active therapy)	No Charge
4920	Unscheduled dressing change (by other than treating dentist)	No Charge
9951	Occlusal adjustment - limited - per visit	No Charge

Prosthodontics (Removable)

5110, 5120	Complete denture (including routine post delivery care)	$110.00
5130, 5140	Immediate denture (including routine post delivery care)	$110.00

Partial dentures (including routine post delivery care):

5211, 5212	Resin base - including clasps, rests, teeth	$90.00
5213, 5214	Cast metal framework with resin base - including clasps, rests, teeth	$130.00

Repairs and adjustments:

5410, 5411, 5421, 5422	Denture adjustments	$5.00
5510, 5610	Repair denture base	No Charge
5520, 5640	Replace missing or broken teeth -per tooth	No Charge
5630	Repair or replace clasp	No Charge
5650	Add tooth to existing partial	No Charge
5660	Add clasp to existing partial	No Charge

5710, 5711, 5720, 5721	Rebase denture	No Charge
5730, 5731, 5740, 5741	Reline denture (chairside)	No Charge
5750, 5751, 5760, 5761	Reline denture (laboratory)	No Charge
5820, 5821	Interim partial denture (stayplate)	$45.00
5850, 5851	Tissue conditioning	No Charge

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Oral Surgery

7110, 7120	Extraction - single tooth	No Charge
7130	Root removal - exposed roots	No Charge
7210	Surgical removal of erupted tooth	$20.00
7220	Removal of impacted tooth - soft tissue	$25.00
7230	Removal of impacted tooth - partially bony	$35.00
7240	Removal of impacted tooth - completely bony	$40.00
7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$40.00
7250	Surgical removal of residual tooth roots (cutting procedure)	$20.00
7270	Tooth reimplantation and/or stabilization of accidentally evulsed tooth	$30.00
7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons	$45.00
7281	Surgical exposure of impacted or unerupted tooth to aid eruption	$30.00
7285	Biopsy of oral tissue - hard	$25.00
7286	Biopsy of oral tissue - soft	$20.00
7310	Alveoplasty in conjunction with extractions - per quadrant	$15.00
7320	Alveoplasty not in conjunction with extractions - per quadrant	$25.00
7450	Removal of odontogenic cyst/tumor - up to 1.25 cm	$30.00
7451	Removal of odontogenic cyst/tumor - over 1.25 cm	$55.00
7470	Removal of exostosis - maxilla or mandible	$40.00
7510	Incision & drainage of intraoral abscess	$15.00
7960	Frenectomy (separate procedure)	$30.00

Miscellaneous Services

9110	Palliative (emergency) treatment	No Charge
9215	Local anesthesia	No Charge

+ Covered services are subject to this plan's exclusions, limitations and *plan* provisions. Other codes may be used to describe covered services.

* There will be an additional *patient charge* for the actual cost of gold/high noble metal for these procedures.

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MDC CODES+	DESCRIPTION OF SERVICE	PATIENT CHARGE
	Orthodontics	
8601	Orthodontic evaluation and consultation	$100.00

8602	Orthodontic treatment plan and records, including x-rays, study models and diagnostic photos	$150.00
8070, 8080, 8090	Comprehensive orthodontic treatment, including fabrication and insertion of fixed banding appliance and periodic visits, up to 24 months: dependent child to age 18 (as determined by the *member's* age on the date of banding)	$1975.00
8070, 8080, 8090	Comprehensive orthodontic treatment, including fabrication and insertion of fixed banding appliance and periodic visits, up to 24 months: employee, spouse and dependent child over age 18 (as determined by the *member's* age on the date of banding)	$2175.00
8670	Periodic comprehensive orthodontic treatment visit	No Charge
8680	Orthodontic retention	$300.00

+ Covered Services are subject to this *plan's* exclusions, limitations and *plan* provisions. Other codes may be used to describe Covered Services.

* These Orthodontic *patient charges* are valid only for authorized services rendered by *participating orthodontists* in the State of California.

Option B

Additional Conditions on Covered Services

General Guidelines for Alternative Procedures

There may be a number of accepted methods of treating a specific dental condition. When a *member* selects an *alternative procedure* over the service recommended by the *PCD,* the *member* must pay the difference between the *PCD's* usual charges for the recommended service and the *alternative procedure.* He or she will also have to pay the applicable *patient charge* for the recommended service.

When the *PCD* recommends a crown, the *alternative procedure* policy does not apply, regardless of the type of crown placed. The type of crown includes, but is not limited to: (a) a full metal crown; (b) a porcelain fused to metal crown; or (c) a porcelain crown. The *member* must pay the applicable *patient charge* for the crown actually placed. The *member* must also pay the additional cost of high noble metal, if high noble metal is selected.

Crowns, Bridges and Dentures

A crown is a covered service when it is recommended by the *PCD.* The replacement of a crown or bridge is not covered within 5 years of the original placement under the *plan.*

The replacement of a partial or complete denture is covered only if the existing denture cannot be made satisfactory by reline, rebase or repair. Construction of new dentures may not exceed one each in any 5 year period from the date of previous placement under the *plan.*

The benefit for complete dentures includes all usual post-delivery care including adjustments for six months after insertion. The benefit for immediate dentures: (a) includes limited follow-up care only for six months; and (b) does not include required future rebasing or relining procedures or a complete new denture.

Multiple Crown/Bridge Unit Treatment Fee

A *member's* approved treatment plan may include 6 or more covered units of crown and/or bridge to restore teeth or replace missing teeth. In such case, the *member* must pay both: (a) the usual crown or bridge *patient charge* for each unit of crown or bridge; and (b) an additional charge per unit. These charges are shown in the Covered Dental Services And Patient Charges section.

Crown Supporting Existing Partial Denture

A crown may be: (a) placed under an existing partial denture; and (b) be customized to physically support the metal framework of the partial denture. In such case, the *member* must pay the *patient charge* for a crown supporting an existing partial denture. This charge is shown in the Covered Dental Services And Patient Charges section. This charge is in addition to the *patient charge* for the crown or bridge unit itself. The *patient charge* for a crown supporting an existing partial denture does not apply to a unit of crown or bridge for which the *member* must pay the *patient charge* for a multiple crown/bridge unit treatment plan.

Pediatric Specialty Services

During a *PCD* visit, a *member* under age 6 may be unmanageable. In such case, the *member* may be referred to a *participating pediatric specialist* for the current treatment plan only. Following completion of that authorized pediatric treatment plan, the *member* must return to the *PCD* for further services. Later referrals to the *participating pediatric specialist,* if any, must first be authorized by MDC. Any services performed by a *pediatric specialist* after the *member's* 6th birthday will not be covered. And the *member* must pay the *pediatric specialist's* usual charges for such services.

Second Opinion Consultation

A Member or the Member's PCD may request the Member consult another Dentist for a second opinion regarding services reommended or performed by: (a) his or her PCD; or (b) a participating specialist through an authorized referral. To have a second opinion consultation covered by MDC, you must call or write Member Services for prior authorization. We only cover a second opinion consultation when the recommended services are otherwise covered under the Plan. Authorizations for second opinions are valid for sixty (60) days from the date of approval.

The request for a second opinion may be approved at the time of the request, or within 72 hours if an emergency exists.

A Member Services Representative will help you identify a Participating Dentist to perform the second opinion consultation. You may request a second opinion with a non-participating general Dentist or specialist dentist. The Member Services Representative will arrange for any available records or radiographs and the necessary second opinion form to be sent to the consulting dentist. Once the second opinion consultation is completed and the Second Opinion Form is returned to the Member Servics Representative, you and your dentist will receive a copy of the findings and recommendations.

The Plan's benefit for a second opinion consultation is $50.00 If a participating dentist is the consultant, there is no cost to you. If a non-participating dentist is the consutlant, you may pay any portion of his or her fee over $50.

We will not deny a request for a second opinion until it has been reviewed by the Dental Director or Designee. All appeals of denials will be reviewed by the Grievance and/or Peer Review Committee. If the request for a second opinion is denied, the Member and/or PCD will receive a written notice of the reasons for the denial. The notice will also state the Member and/or PCD has the right to contact the Member Services Department to file a grievance.

MDC has a written policy describing the timeline for second opinions and how we administer the second opinion program. You may request a complete copy of MDC's written policy by contacting the Member Services Department at 800-273-3330, or by mail at P.O. Box 4391, Woodland Hills, CA 91367.

Noble and High Noble Metals

The *plan* provides for the use of noble metals for inlays, onlays, crowns and fixed bridges. When high noble metal (including "gold") is used, *you* must pay: (a) the usual *patient charge* for the inlay, onlay, crown or fixed bridge; plus (b) an added charge equal to the actual laboratory cost of the high noble metal.

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Option B

Orthodontic Treatment

This *plan* covers orthodontic services as shown in Covered Dental Services And Patient Charges. Coverage is limited to one course of treatment per *member* per lifetime. Treatment must be: (a) preauthorized by MDC; and (b) performed by a *participating orthodontist.*

The *plan* covers up to 24 months of comprehensive orthodontic treatment. If treatment beyond 24 months is necessary, *you* must pay an added charge for each added month of treatment. Such charge is based on the *participating orthodontist's* contracted fee.

Orthodontic services are not covered if comprehensive treatment begins before the *member* is eligible for benefits under this *plan.*

The covered service for the treatment plan and records includes initial records and any interim and final records. The benefit for comprehensive orthodontic treatment covers the fixed banding appliances and related visits only. *You* must pay for additional fixed or removable appliances. The benefit for orthodontic retention covers: (a) any and all necessary fixed and removable appliances; and (b) related visits. Retention services are covered only following a course of comprehensive orthodontic treatment covered under the *plan.* Limited orthodontic treatment and interceptive (Phase I) treatment are not covered.

The *plan* does not cover any incremental charges for orthodontic appliances made with: (a) clear; (b) ceramic; (c) white or other optional material; or (d) lingual brackets.

If a *member* has orthodontic treatment associated with orthognathic surgery, the *plan* provides its standard orthodontic benefit. Orthognathic surgery is a non-covered procedure involving the surgical moving of teeth. *You* must pay any added charges related to: (a) the orthognathic surgery; and (b) the complexity of the orthodontic treatment. The added charges will be based on the *participating orthodontist's* usual and customary charge.

CGP-3-MDCGG2-A B850.0822

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Limitations on Benefits for Specific Covered Services

We don't pay benefits in excess of any of the following limitations:

- Routine cleaning (prophylaxis) or periodontal maintenance procedure - 2 services in any 12 month period. One periodontal maintenance procedure may be performed by a *participating periodontist* if done within 3 to 6 months following completion of approved, active periodontal therapy by the *participating periodontist.* Such therapy includes periodontal scaling and root planing or periodontal surgery.
- Fluoride treatment - up to the 18th birthday - 2 in any 12 month period.
- Full mouth x-rays - one set in any 3 year period unless diagnostically necessary.
- Bitewing x-rays - 2 sets in any 12 month period unless diagnostically necessary.
- Panoramic x-rays - one in any 3 year period unless diagnostically necessary.
- Sealants - limited to molars, up to the 16th birthday - one per tooth in any 3 year period.
- Gingival flap procedure (4240) or osseous surgery (4260, 4261) - one service per quadrant or area in any 3 year period.
- Periodontal soft tissue graft procedure (4270, 4271) - one service per area in any 3 year period.
- Periodontal scaling and root planing - one service per quadrant in any 12 month period.

- *Emergency dental services* when more than 50 miles from the *PCD's* office - up to $50.00 per incident.
- Reline of a complete or partial denture - one per denture in any 12 month period.
- Rebase of a complete or partial denture - one per denture in any 12 month period.
- Second opinion consultation - when approved by MDC, up to $50.00.

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Option B

Exclusions

We won't pay for:

- any condition for which benefits of any nature are paid, whether by adjudication or settlement, under any Workers' Compensation or Occupational Disease Law. This will apply even if the *member* fails to claim his or her rights to such benefit.
- hospitalization costs (and any associated charges, including but not limited to, physician charges, prescriptions or medications), for any dental services performed on an inpatient or outpatient basis in a hospital.
- any histopathological examinations, or removal of tumors, cysts, neoplasms or foreign bodies that are not tooth related.
- any treatment of congenital and/or developmental malformations. This will not apply to an otherwise covered service involving: (a) congenitally missing teeth; or (b) supernumerary teeth.
- any oral surgery requiring the setting of a fracture or dislocation.
- dispensing of drugs not normally supplied in a dental office for treatment of dental diseases.
- any treatment or appliance: (a) which, in the opinion of the *participating dentist,* is not necessary for maintaining or improving the *member's* dental health; or (b) which is solely for cosmetic purposes.
- precision attachments, stress breakers, magnetic retention or overdenture attachments.
- the use of: (a) general anesthesia; (b) intramuscular sedation; (c) intravenous sedation; or (d) inhalation sedation, including but not limited to nitrous oxide.
- any procedure or treatment method: (a) which does not meet professionally recognized standards of dental practice; or (b) which is considered to be experimental in nature.
- replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.

- any *member* request for: (a) specialist services or treatment which can be routinely provided by the *PCD;* or (b) treatment by a specialist without referral from the *PCD* and MDC approval.
- treatment provided by any public program, except Medicaid, or paid for or sponsored by any government body, unless we are legally required to provide benefits.
- any restoration, service, appliance or prosthetic device used solely to: (a) alter vertical dimension; (b) replace tooth structure lost due to attrition or abrasion; or (c) splint or stabilize teeth for periodontal reasons.
- any service, appliance, device or modality intended to treat disturbances of the temporomandibular joint (TMJ).
- dental services received from any *dentist* other than the selected and assigned *PCD,* unless expressly authorized in writing by the *plan.* This will not apply to covered *emergency dental services.*
- cephalometric x-rays, except when performed as part of the orthodontic treatment plan and records for a covered course of comprehensive orthodontic treatment.
- treatment which requires the services of a *prosthodontist.*
- treatment which requires the services of a *pediatric specialist,* after the *member's* 6th birthday.
- consultations for non-covered services.
- any procedure not listed as a covered service.
- any service or procedure: (a) associated with the placement, prosthodontic restoration or maintenance of a dental implant; and (b) any incremental charges to other covered services as a result of the presence of a dental implant.
- inlays, onlays, crowns or fixed bridges started but not completed prior to the *member's* eligibility to receive benefits under this *plan.* (Inlays, onlays, crowns or fixed bridges are: (a) started when the tooth or teeth are prepared; and (b) completed when the final restoration is permanently cemented.)
- root canal treatment started but not completed prior to the *member's* eligibility to receive benefits under this *plan.* (Root canal treatment is: (a) started when the pulp chamber is opened; and (b) completed when the permanent root canal filling material is placed.)
- inlays, onlays, crowns or fixed bridges started (as defined above) by a *non-participating dentist.* This will not apply to covered *emergency dental services.*
- dentures or orthodontic treatment started prior to the *member's* eligibility to receive benefits under this *plan.* (Dentures are started when the impressions are taken. Orthodontic treatment is started when the teeth are banded.)

- root canal treatment started (as defined above) by a *non- participating dentist.* This will not apply to covered *emergency dental services.*
- extractions performed solely to facilitate orthodontic treatment.
- extractions of impacted teeth with no radiographic evidence of pathology. The removal of impacted teeth is not covered if performed for prophylactic reasons.
- orthognathic surgery and associated incremental charges. Orthognathic surgery is a procedure which involves the surgical moving of teeth.
- procedures performed to facilitate non-covered services, including but not limited to: (a) root canal therapy to facilitate either hemisection or root amputation; and (b) osseous surgery to facilitate either guided tissue regeneration or an osseous graft.
- procedures, appliances or devices: (a) to guide minor tooth movement; or (b) to correct or control harmful habits.
- any endodontic, periodontal, crown or bridge abutment procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- re-treatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident.
- replacement or repair of orthodontic appliances damaged due to the neglect of the *member.*

Option B

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

Act means the Knox-Keene Health Care Service Plan of 1975 (California Health and Safety Code Sections 1340 et seq).

CGP-3-MDCD B850.0826

Option B

Combined Evidence of Coverage and Disclosure Form means this booklet issued to *you,* which summarizes the essential terms of this *plan.*

CGP-3-MDCD2 B850.0207

Option B

Dentist means any dental practitioner who: (a) is properly licensed or certified under the laws of the state where he or she practices; and (b) provides services which are within the scope of his or her license or certificate and covered by this *plan.*

CGP-3-MDCD3 B850.0208

Option B

Dependent means the spouse and dependent children of the employee as defined herein under the section entitled Eligible Dependents.

CGP-3-MDCDMST-C B850.1472

Option B

Emergency Dental Services are defined as dental services limited to procedures administered in a hospital, dentist's office, dental clinic, or other comparable facility, to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe pain, acute infection, fever, swelling or to prevent the imminent loss of teeth that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed and which are covered under this plan.

CGP-3-MDCD5 B850.0828

Option B

Employee or You means a person: (a) who meets your *employer's* eligibility requirements; and (b) for whom your *employer* makes monthly payments under this *plan.*

CGP-3-MDCD6 B850.0213

Option B

Employer or Planholder means your *employer* or other entity: (a) with whom or to whom this *plan* is issued; and (b) who agrees to collect and pay the applicable premium on behalf of all its *members.*

CGP-3-MDCD7 B850.0214

Option B

Member means *you* and any of your eligible *dependents* : (a) as defined under the eligibility requirements of this *plan;* and (b) as determined by your *employer,* who are actually enrolled in and eligible to receive benefits under this *plan.*

CGP-3-MDCD8 B850.0215

Option B

Non-Participating Dentist means any *dentist* who is not under contract with MDC to provide dental services to *members.*

CGP-3-MDG-DEF9 B850.0217

Option B

Participating Dentist means a *dentist* under contract with MDC.

CGP-3-MDCD10 B850.0829

Option B

Participating General Dentist means a *dentist* under contract with MDC: (a) who is listed in MDC's directory of *participating dentists* as a general practice *dentist;* and (b) who may be selected as a *PCD* by a *member* and assigned by MDC to provide or arrange for a *member's* dental services.

CGP-3-MDCD11 B850.0219

Option B

Participating Specialist means a *dentist* under contract with MDC as an: (a) *endodontist;* (b) *pediatric specialist;* (c) *periodontist;* (d) *oral surgeon* or (e) *orthodontist.*

CGP-3-MDC12-B B850.0220

Option B

Patient Charge means the amount, if any, specified in the Covered Dental Services And Patient Charges section of this *plan.* Such amount is the patient's portion of the cost of covered dental services.

CGP-3-MDCD13 B850.0222

Option B

Plan means the MDC group *plan* for dental services described in this booklet.

CGP-3-MDCD14 B850.0223

Option B

Primary Care Dentist (PCD) means a dental office location: (a) at which one or more *participating general dentists* provide *covered services* to *members;* and (b) which has been selected by a *member* and assigned by MDC to provide and arrange for his or her dental services.

CGP-3-MDCD15 B850.0224

Option B

Service Area means the geographic area in which MDC is licensed to provide dental services for *members.*

CGP-3-MDCD16 B850.0225

Option B

We, Us, Our and MDC mean Managed Dental Care of California.

CGP-3-MDCD17 B850.0226

Option B

COORDINATION OF BENEFITS

Coordination of Benefits (COB) is a process, regulated by law, which determines the financial responsibility for payment when a Member has coverage under more than one plan. The primary carrier pays up to its maximum liability and the secondary carrier considers the remaining balance for covered services up to, but not exceeding, the benefits that are available and the Dentist's actual charge.

Determination of primary coverage is as follows:

For Adults A plan covering an adult as an Employee is primary, and determines its benefits first. A plan covering an adult as a Dependent (through a plan from a spouse's Employer) is secondary, and determines its benefits only after the primary plan's benefits have been paid.

If a person is covered as an Employee or a former Employee under more than one plan, a plan which covers him or her as an active Employee determines benefits before any Plan covering the person as a laid-off or retired Employee. Otherwise, the plan covering that person longer determines its benefits before the other plan does.

For Dependent Children

The determination of primary and secondary coverage for Dependent Children covered by two parents' plans follows the birthday rule. The plan of the parent with the earlier birthday (month and day, not year) is the primary coverage. Different rules apply for the children of divorced or legally separated parents; contact the Member Services Department if you have any questions.

Coverage under MDC and another prepaid dental plan: When an MDC Member has coverage under another prepaid plan, whether MDC is the primary or the secondary coverage, PCD may not collect more than the applicable copayment from the Member.

Coverage under MDC and a traditional or PPO fee for service plan: When a Member is covered by MDC and a fee for service plan, the following rules will apply:

When MDC is the primary plan (e.g., when an MDC Member also has fee for service coverage under a spouse's plan), you may only bill the secondary carrier for the Patient Charge amount. Any payment made by the secondary carrier must be credited against the Member's payment.

When MDC is the secondary plan (e.g., when an MDC Member's eligible Dependent spouse has fee for service coverage through his or her Employer), PCD should bill the primary plan first. The primary payment is then credited against the Patient Charge. The Member will be responsible for a payment only if the primary carrier's payment is less than the applicable MDC Copayment.

When an MDC Member with other coverage receives authorized services from a Participating Specialist Dentist, and MDC is primary, the MDC benefits are paid without regard to the other coverage. When MDC is the secondary plan, any payment made by the primary carrier is credited against the copayment. MDC will then issue payment of the Specialist up to the unpaid remainder of the fee schedule amount. In many cases the Member will have no out-of-pocket expenses.

MDC will not coordinate or pay for the following:

Any condition for which benefits of any nature are paid, whether by adjudication or settlement, under any Workers' Compenstaion or Occupational Disease law.

Treatment provided by any public program, except Medicad, or paid for or sponsored by any goverment body, unless we are legally required to provide benefits.

STATEMENT OF ERISA RIGHTS

As a participant, an employee is entitles to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants will be entitled to:

Receive Information about the Plan and Benefits:

a. Examine, without charge, at the plan administrator's office and at other specified locations such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

b. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a resonsable charge for the copies.

c. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Dental Health Plan Coverage

Continue dental health care coverage for the employee, his or her spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. The employee and his or her dependents may have to pay for such coverage. The employee whould review the summary plan description and the documents governing the plan on the rules governing his or her COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of plan participants and beneficiaries. No one, including the employer, an employee's unioin, or any other person may fire an employee or otherwise discriminate against him or her in any way to prevent the employee from obtaining a welfare benefit or exercising his or her rights under ERISA.

Enforcement of An Employee's Rights

If an employee's claim for a welfare benefit is denied or ignored, in whole or in part, he or she has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps an employee can take to enforce the above rights. For instance, if an employee requests a copy of plan documents or the latest annual report from the plan and does not receive them within 30 days, he or she may file suit in a state or Federal court. In such a case, the court may require the plan administrator to provide the materials and pay the employee up to $110 a day until he or she receives the material, unless the materials were not sent because of reasons beyond the control of the administrator. If an employee has a claim for benefits which is denied or ignored, in whole or in part, he or she may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money or if an employee is discriminated against for asserting his or her right, the employee may seek assistance from the U.S. Department of Labor, or he or she may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If an employee is successful, the court may order the person he or she sued to pay these costs and fees. If the employess loses, the court may order him or her to pay these costs and fees, for example, if it finds that the employee's claim is frivoious.

Assistance with Questions

If an employee has questions about the plan, he or she should contact the plan administrator. If an employee has questions about this statement or about his or her rights under ERISA, or if the employee needs assistance in obtaining documents from the plan administrator, he or she should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210. An employee may also obtain certain publications about his or her rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

CGP-3-MDCER B850.0831

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

PLAN 90	**Deductibles**	**Lifetime Maximums**	**Professional Services**			
			Diagnostic	Preventive	Restorative	Endodontic
	None					
Services			Oral Evaluations; X-Rays: Intraoral Panorex; Miscellaneous: Primary Care Diagnostic Services	Prophylaxis (Cleaning); Flouride; Sealants; Space Maintainers	Amalgam & Resin: Restorations (Fillings); Crowns And Pontics; Inlay And Onlay Miscellaneous: Restorative Services	Pulp Cap; Pulpotomy; Root Canals; Retreatments; Apicoectomy; Retrograde Filling
Patient Charge Range			No Charge	Prophylaxis - $0; Flouride - $0; Sealants - $0; Space Maintainers - $0	Amalgam - $0; Resin - $0; Crowns - $90 - $100; Inlays & Onlays - $60 - $80; Miscellaneous: Restorative Services - $0 - $40	Pulp Cap - $0; Pulpotomy - $0; Root Canals - $0 - $90; Retreatments - $0 - $95; Apicoectomy: - First Root - $55 - $80; Each Additional Root - $25; Retrograde Filling - Per Root - $10
Limitations		One Course Of Comprehensive Orthodontic Treatment Per Member Per Lifetime	Full Mouth X-Rays - 1 Set Per 3 Year Period; Bite Wing X-Rays - 2 Sets In Any 12 Month Period; Panoramic - One In Any 3 Year Period	Prophylaxis - 2 In Any 12 Month Period; Flouride Treatment Up To 18th Birthday - 2 In Any 12 Month Period; Sealants - Limited To Molars, Up To 16th Birthday, One Per Tooth In Any 3 Year Period	Crown Replacement - Once Per 5 Years; Actual Cost Of Gold/High Noble Metal Is Member's Responsibility	

B850.0865

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. (CONTINUED)

Plan 90 (Continued)	**Professional Services (Continued)**				
	Periodontic	Prosthodontics	Oral Surgery	Orthodontic	Adjunctive General Services
Services (Continued)	Gingivectomy/ Gingivoplasty; Gingival Flap Procedure; Osseous Surgery; Scaling & Root Planing; Soft Tissue Graft; Crown Lengthening; Miscellaneous Periodontal Services	Complete Dentures; Partial Dentures; Relines; Repairs; Denture Adjustments	Extractions; Biopsy; Alveoplasty; Incision And Drainage; Frenectomy/ Frenulectomy; Removal Of Cyst/Tumor	Comprehensive Treatment; Retention; Evaluation And Consultation; Treatment Plan And Records	Office Visit; Palliative Treatment; Local Anesthesia
Patient Charge Range (Continued)	Gingivectomy/ Gingivoplasty - $15 - $35*; Gingival Flap Procedure - $65; Osseous Surgery - $60 - $95*; Scaling & Root Planing - $0; Soft Tissue Graft - $65 - $70; Crown Lengthening - $55; Miscellaneous Periodontal Services - $0 *Limited - Quadrant	Complete Dentures - $110; Partial Dentures - $45 - $130; Reline - $0; Repair - $0; Denture Adjustment - $5	Simple Extractions - Removal Of Complete Bony Impactions - $0 - $45; Biopsy, Oral Tissue - $20 - $25; Alveoplasty - $15 - $25 Incision And Drainage - $15 Frenectomy/ Frenulectomy - $30; Removal Of Cyst/Tumor - $30 - $55	To Age 18 - $1975 Over Age 18 - $2175; Retention - $300; Evaluation and Consultation - $100; Treatment Plan And Records - $150	Office Visit - $0 - $5; After Hours Office Visit - $50; Palliative Treatment - $0 Local Anesthesia - $0

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. (CONTINUED)

Plan 90 (Continued)	**Professional Services (Continued)**				
	Periodontic	Prosthodontics	Oral Surgery	Orthodontic	Adjunctive General Services
Limitations (Continued)	Gingival Flap/ Osseous Surgery - One Service Per Quadrant Or Area In Any 3 Year Period; Soft Tissue Graft - One Service Per Area In Any 3 Year Period; Scaling And Root Planing - One Per Quadrant In Any 12 Month Period	Actual Cost Of Gold/High Noble Metal Is Member's Responsibility; Reline Of Denture - One Per Denture In Any 12 Month Period; Rebase Of Denture - One Per Denture In Any 12 Month Period	Impacted Teeth - Radiographic Evidence Of A Pathology; Limited To Non-Orthodontic Extractions; Biopsy - Tooth Related Only; Removal Of Cyst/ Tumor - Tooth Related Only	One Course of Comprehensive Treatment Per Member Per Lifetime; 24 Months Of Active Treatment; Limited To Fixed Banding Appliances Only; Limited To Initial Comprehensive Treatment Only	

B850.0866

THIS IS A REVISED UNIFORM MATIRX WHICH SUPERSEDES ANY OTHER UNIFORM MATRIX INCLUDED IN THE EVIDENCE OF COVERAGE/DISCLOSURE FORM.

REGULATIONS REQUIRE THE PLAN TO PROVIDE A UNIFORM HEALTH PLAN BENEFITS AND COVERAGE MATRIX.

MDG 90 0899

B850.0898

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. (CONTINUED)

PLAN 90	Outpatient Services	Hospitalization Service	Emergency Health Coverage		Ambulance Services	Prescription Drug Services
			In-Area Emergency Dental Service	Out-Of-Area Emergency Dental Service		
	Not Covered*	Not Covered*	MDC Network Provides For Emergency Dental Services 24 Hours Per Day, 7 Days Per Week	Emergency Dental Service When More Than 50 Miles From Primary Care Dentist's Office: Limited to $50 Reimbursement Per Incident	Not Covered*	Not Covered*

PLAN 90 (CONT.)	Durable Medical Equipment	Mental Health Services	Chemical Dependency Services	Home Health Services	Other
	Not Covered*	Not Covered*	Not Covered*	Not Covered*	Not Covered*

***SERVICES LISTED AS "NOT COVERED" ARE GENERALLY INAPPLICABLE TO DENTAL COVERAGE.**

THIS IS A REVISED UNIFORM MATRIX WHICH SUPERSEDES ANY OTHER UNIFORM MATRIX INCLUDED IN THE EVIDENCE OF COVERAGE/DISCLOSURE FORM.

REGULATIONS REQUIRE THE PLAN TO PROVIDE A UNIFORM HEALTH PLAN BENEFITS AND COVERAGE MATRIX.

MDG 90 0899

B850.0867

All Options

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective: 9/23/2013

This Notice of Privacy Practices describes how Guardian and its subsidiaries may use and disclose your Protected Health Information(PHI) in order to carry out treatment, payment and health care operations and for other purposes permitted or required by law.

Guardian is required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices concerning PHI. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all PHI maintained by us. If we make material changes to our privacy practices, copies of revised notices will be made available on request and circulated as required by law. Copies of our current Notice may be obtained by contacting Guardian(using the information supplied below), or on our Web site at: www.GuardianLife.com/PrivacyPolicy

What is Protected Health Information (PHI):

PHI is individually identifiable information(including demographic information) relating to your health, to the health care provided to you or to payment for health care. PHI refers particularly to information acquired or maintained by us as a result of your having health coverage(including medical, dental, vision and LTC coverage).

In What Ways may Guardian Use and Disclose your Protected Health Information (PHI):

Guardian has the right to use or disclose your PHI without your written authorization to assist in your treatment, to facilitate payment and for health care operations purposes. There are certain circumstances where we are required by law to use or disclose your PHI. And there are other purposes, listed below, where we are permitted to use or disclose your PHI without further authorization from you. Please note that examples are provided for illustrative purposes only and are not intended to indicate every use or disclosure that may be made for a particular purpose.

Guardian has the right to use or disclose your PHI for the following purposes:

Treatment. Guardian may use and disclose your PHI to assist your health care providers in your diagnosis and treatment. For example, we may disclose your PHI to providers to supply information about alternative treatments.

Payment. Guardian may use and disclose your PHI in order to pay for the services and resources you may receive. For example, we may disclose your PHI for payment purposes to a health care provider or a health plan. Such purposes may include: ascertaining your range of benefits; certifying that you received treatment; requesting details regarding your treatment to determine if your benefits will cover, or pay for, your treatment.

Health Care Operations. Guardian may use and disclose your PHI to perform health care operations. For example, we may use your PHI for underwriting and premium rating purposes.

Appointment Reminders. Guardian may use and disclose your PHI to contact you and remind you of appointments.

Health Related Benefits and Services. Guardian may use and disclose PHI to inform you of health related benefits or services that may be of interest to you.

Plan Sponsors. Guardian may use or disclose PHI to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan may contact us regarding benefits, service or coverage issues. We may also disclose summary health information about the enrollees in your group health plan to the plan sponsor so that the sponsor can obtain premium bids for health insurance coverage, or to decide whether to modify, amend or terminate your group health plan.

B998.0046

All Options

Guardian is required to use or disclose your PHI:

- To you or your personal representative (someone with the legal right to act for you);
- To the Secretary of the Department of Health and Human Services, when conducting a compliance investigation, review or enforcement action; and
- Where otherwise required by law.

Guardian is Required to Notify You of any Breaches of Your PHI.

Although Guardian takes reasonable, industry-standard measures to protect your PHI, should a breach occur, Guardian is required by law to notify affected individuals. A breach means the acquisition, access, use, or disclosure of PHI in a manner not permitted by law that compromises the security or privacy of the PHI.

Other Uses and Disclosures .

Guardian may also use and disclose your PHI for the following purposes without your authorization:

- We may disclose your PHI to persons involved in your care, such as a family member or close personal friend, when you are incapacitated, during an emergency or when permitted by law.
- We may disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations.
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI to a government oversight agency authorized by law to conducting audits, investigations, or civil or criminal proceedings.
- We may disclose your PHI in the course of a judicial or administrative proceeding(e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.
- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for organ or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services, and we may also disclose your PHI for other specialized government functions such as national security or intelligence activities.
- We may disclose your PHI to comply with workers' compensation and other similar programs.
- We may disclose your PHI to third party business associates that perform services for us, or on our behalf (e.g. vendors).
- Guardian may use and disclose your PHI to federal officials for intelligence and national

security activities authorized by law. We also may disclose your PHI to authorized federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations authorized by law.

- We may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official (e.g., for the institution to provide you with health care services, for the safety and security of the institution, and/or to protect your health and safety or the health and safety of other individuals).
- We may disclose your PHI to your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

All Options

Your Rights with Regard to Your Protected Health Information (PHI): Your Authorization for Other Uses and Disclosures. Other than for the purposes described above, or as otherwise permitted by law, Guardian must obtain your written authorization to use or disclosure your PHI. You have the right to revoke that authorization in writing except to the extent that: (i) we have taken action in reliance upon the authorization prior to your written revocation,(ii) you were required to give us your authorization as a condition of obtaining coverage, or (iii) and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Under federal and state law, certain kinds of PHI will require enhanced privacy protections. These forms of PHI include information pertaining to:

- HIV/AIDS testing, diagnosis or treatment
- Venereal and /or communicable Disease(s)
- Genetic Testing
- Alcohol and drug abuse prevention, treatment and referral
- Psychotherapy notes

We will only disclose these types of delineated information when permitted or required by law or upon your prior written authorization.

Your Right to an Accounting of Disclosures. An 'accounting of disclosures' is a list of the disclosures we have made, if any, of your PHI. You have the right to receive an accounting of certain disclosures of your PHI that were made by us. This right applies to disclosures for purposes other than those made to carry out treatment, payment and health care operations as described in this notice. It excludes disclosures made to you, or those made for notification purposes.

We ask that you submit your request in writing. Your request must state a requested time period not more than six years prior to the date when you make your request. Your request should indicate in what form you want the list(e.g., paper, electronically).

Your Right to Obtain a Paper Copy of This Notice. You have a right to request a paper copy of this notice even if you have previously agreed to accept this notice electronically.

Your Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with the U.S. Secretary of Health and Human Services. If you wish to file a complaint with Guardian, you may do so using the contact information below. You will not be penalized for filing a complaint.

Any exercise of the Rights designated below must be submitted to the Guardian in writing. Guardian may charge for reasonable costs associated with complying with your requests; in such a case, we will notify you of the cost involved and provide you the opportunity to modify your request before any costs are incurred.

Your Right to Request Restrictions. You have the right to request a restriction on the PHI we use or disclose about you for treatment, payment or health care operations as described in this notice. You also have the right to request a restriction on the medical information we disclose about you to someone who is involved in your care or the payment for your care.

Guardian is not required to agree to your request; however, if we do agree, we will comply with your request until we receive notice from you that you no longer want the restriction to apply(except as required by law or in emergency situations). Your request must describe in a clear and concise manner: (a) the information you wish restricted; (b) whether you are requesting to limit Guardian's use, disclosure or both; and (c) to whom you want the limits to apply.

Your Right to Request Confidential Communications. You have the right to request that Guardian communicate with you about your PHI be in a particular manner or at a certain location. For example, you may ask that we contact you at work rather than at home. We are required to accommodate all reasonable requests made in writing, when such requests clearly state that your life could be endangered by the disclosure of all or part of your PHI.

B998.0048

All Options

Your Right to Amend Your PHI . If you feel that any PHI about you, which is maintained by Guardian, is inaccurate or incomplete, you have the right to request that such PHI be amended or corrected. Within your written request, you must provide a reason in support of your request. Guardian reserves the right to deny your request if: (i) the PHI was not created by Guardian, unless the person or entity that created the information is no longer available to amend it(ii) if we do not maintain the PHI at issue(iii) if you would not be permitted to inspect and copy the PHI at issue or (iv) if the PHI we maintain about you is accurate and complete. If we deny your request, you may submit a written statement of your disagreement to us, and we will record it with your health information.

Your Right to Access to Your PHI. You have the right to inspect and obtain a copy of your PHI that we maintain in designated record sets. Under certain circumstances, we may deny your request to inspect and copy your PHI. In an instance where you are denied access and have a right to have that determination reviewed, a licensed health care professional chosen by Guardian will review your request and the denial. The person conducting the review will not be the person who denied your request. Guardian promises to comply with the outcome of the review.

How to Contact Us:

If you have any questions about this Notice or need further information about matters covered in this Notice, please call the toll-free number on the back of your Guardian ID card. If you are a broker please call 800-627-4200. All others please contact us at 800-541-7846. You can also write to us with your questions, or to exercise any of your rights, at the address below:

Attention:

Guardian Corporate Privacy Officer
National Operations

Address:

The Guardian Life Insurance Company of America
Group Quality Assurance - Northeast
P.O. Box 2457
Spokane, WA 99210-2457

B998.0049

YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE

www.GuardianAnytime.com

Insured employees and their dependents can access helpful, secure information about their Guardian benefits(s) online at:

GuardianAnytime.com - 24 hours a day, 7 days a week.

Anytime, anywhere you have an internet connection you will be able to:

- Review your benefits
- Look up coverage amounts
- Check the status of a claim
- Print forms and plan materials
- And so much more!

To register, go to www.GuardianAnytime.com

GUARDIAN℠

The Guardian Life Insurance Company of America
7 Hanover Square
New York, New York 10004-2616

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